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NATIONAL HEALTH PROGRAM, 1949

HEARINGS

BEFORE A

SUBCOMMITTEE OF THE
COMMITTEE ON LABOR AND PUBLIC WELFARE
UNITED STATES SENATE

EIGHTY-FIRST CONGRESS
FIRST SESSION

ON

S. 1106, S. 1456, S. 1581, and S. 1679

BILLS RELATIVE TO A NATIONAL
HEALTH PROGRAM

PART 1

MAY 23, 24, 25, 31, JUNE 1, 2, 1949

Printed for the use of the Committee on Labor and Public Welfare

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U.S. Congress. Senate. Committee on Labor and Public Welfare.

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CONTENTS

I. Alphabetical List of Witnesses

Page
Bauer, Dr. Louis H., Hempstead, N. Y., on behalf of American Medical Association 201
Brown, Harvey W., president, International Association of Machinists 611
Carey, James B., secretary-treasurer, Congress of Industrial Organizations 417
Cruikshank, Nelson H., director of social insurance activities, American Federation of Labor 281, 307
Flagstad, Dr. Carl O., Minneapolis, Minn., on behalf of American Dental Association 189
Goin, Dr. Lowell S., Los Angeles, Calif., president, California Physicians' Service 216
Harris, Seymour E., professor of economics, Harvard University, on behalf of Americans for Democratic Action 149
Hawley, Dr. Paul R., chief executive officer, Blue Cross-Blue Shield Commissions 332
Hayes, John H., chairman, council on Government relations, American Hospital Association 438
Hill, Hon. Lister, a United States Senator from the State of Alabama 139
Hilton, Mrs. Anna, Camden, N. J 423
Hutcheson, Dr. R. H., president, State and Territorial Health Officers Association, and commissioner of public health, Nashville., Tenn 541
Kingsley, J. Donald, Acting Federal Security Administrator 79
Leavell, Dr. Hugh R., professor of public health practice, Harvard School of Public Health, and chairman, executive board, American Public Health Association, New York, N. Y 564
Lodge, Hon. Henry Cabot, Jr., a United States Senator from the State of Massachusetts 296
McGowan, Rev. Donald A., director of Bureau of Health and Hospitals, National Catholic Welfare Conference, Washington, D. C 516
Nelson, George, grand lodge representative, International Association of Machinists 616
Olsen, John H., past president, American Protestant Hospital Association 469
Sensenich, Dr. Roscoe, South Bend, Ind 201
Smith, Rt. Rev. Msgr. George Lewis, president, Catholic Hospital Association of the United States and Canada 503
Taft, Hon. Robert A., a United States Senator from the State of Ohio 111
Van Steenwyk, E. A., executive director, the Associated Hospital Service of Philadelphia, and chairman, government relations committee, Blue Cross Commission 405

II. Chronological List of Witnesses

Monday, May 23, 1949: J. Donald Kingsley, Acting Federal Security Administrator 79

Tuesday, May 24, 1949:

Hon. Robert A. Taft, a United States Senator from the State of Ohio 111
Hon. Lister Hill, a United States Senator from the State of Alabama 139

Wednesday, May 25, 1949:

Seymour E. Harris, professor of economics, Harvard University, on behalf of Americans for Democratic Action 149
Dr. Carl O. Flagstad, Minneapolis, Minn., on behalf of American Dental Association 189
Dr. Roscoe Sensenich, South Bend, Ind 201
Dr. Louis H. Bauer, Hempstead, N. Y., on behalf of American Medical Association 201
Dr. Lowell S. Goin, Los Angeles, Calif., president, California Physicians' Service 216

Tuesday, May 31, 1949:

Page
- Nelson H. Cruikshank, director of social insurance activities, American Federation of Labor ____ 281, 307
- Hon. Henry Cabot Lodge, Jr., a United States Senator from the State of Massachusetts ____ 296
- Dr. Paul R. Hawley, chief executive officer, Blue Cross-Blue Shield Commissions ____ 332
- E. A. van Steenwyk, executive director, the Associated Hospital Service of Philadelphia, and chairman, government relations committee, Blue Cross Commission ____ 405

Wednesday, June 1, 1949:

- James B. Carey, secretary-treasurer, Congress of Industrial Organizations ____ 417
- Mrs. Anna Hilton, Camden, N. J ____ 423
- John H. Hayes, chairman, council on government relations, American Hospital Association ____ 438
- John H. Olsen, past president, American Protestant Hospital Association ____ 469
- Rt. Rev. Msgr. George Lewis Smith, president, Catholic Hospital Association of the United States and Canada ____ 503
- Rev. Donald A. McGowan, director of bureau of health and hospitals, National Catholic Welfare Conference, Washington, D. C ____ 516

Thursday, June 2, 1949:

- Dr. R. H. Hutcheson, president, State and Territorial Health Officers Association, and commissioner of public health, Nashville, Tenn ____ 541
- Dr. Hugh R. Leavell, professor of public health practice, Harvard School of Public Health, and chairman, executive board, American Public Health Association, New York, N. Y ____ 564
- Harvey W. Brown, president, International Association of Machinists ____ 611
- George Nelson, grand lodge representative, International Association of Machinists ____ 616

III. List of Statements and Communications

Carey, James B., secretary-treasurer, Congress of Industrial Organizations, insertion of: Excerpts from Government of the People, by the People, for the People, published by the United States Conference of Mayors ____ 422

Cruikshank, Nelson H., director of social-insurance activities, American Federation of Labor, charts submitted by:
- Major benefits provided by health-insurance plan and by United Medical Service "surgical" plan ____ 318
- Major benefits provided by health-insurance plan and by Group Health executive-all-illness plan ____ 319

Donnell, Hon. Forrest C., a United States Senator from the State of Missouri, newspaper article submitted by: Washington Evening Star, December 20, 1948, article by Dorothy Thompson, On the Record—Compulsory Health Insurance Opposed as Being Costly and Impracticable ____ 369

Goin, Dr. Lowell S., Los Angeles, Calif., president, California Physicians' Service, insertions of:
- Document entitled "A Simplified Blueprint of the Campaign Against Compulsory Health Insurance" ____ 224
- Keenan, Dr. A. S., medical director, Health Service System, San Francisco, Calif., letter of, in re health-service system ____ 243

Harris, Seymour E., professor of economics, Harvard University, on behalf of Americans for Democratic Action, document submitted by: The Costs of Health Insurance, by George Soule ____ 177

Murray, Hon. James E., a United States Senator from the State of Montana, insertions of:
- American Journal of Public Health, July 1949, article from, The Quality of Medical Care in a National Health Program ____ 588
- Committee for the Nation's Health, Washington, D. C., article by, Is the British National Health Service Succeeding? ____ 437
- Davis, Michael M., Committee for the Nation's Health, Inc., New York, N. Y., letter of, to Senator Murray, transmitting comments on the pamphlet, Voluntary Approach to a National Health Program ____ 537
- Gilbert, W. C., Assistant Director, Legislative Reference Service, Library of Congress, letter of, to Senator Murray, in re alleged statement of Lenin ____ 280

Murray, Hon. James E., insertions of—Continued Page
  Hawley, Dr. Paul R., chief executive officer, Blue Cross-Blue Shield Commissions, Chicago, Ill., letter to, from Senator Murray, and reply thereto by Dr. Hawley with which was transmitted data requested by Senator Murray 373
  Newspaper articles as follows:
    Memphis Press-Scimitar, February 29, 1949, British doctors praise new national-health program 435
    San Francisco Chronicle (This World), February 22, 1948, the Patient's Dilemma 271
    San Francisco News, June 1949, What Price Health?—California Tops Nation in Medical Care Costs—State Surgical Charges 139 Percent of Those at National Level 276
    San Francisco News, June 17, 1949, What Does It Cost To Be Sick?—Cost of Medical Care Unpredictable Factor 278
    Washington Evening Star, article by Lowell Mellett, On the Other Hand—Some Remarkable Things Being Done in Name of Family Doctors 368
    Senate bill 1106 2
    Senate bill 1456 4
    Senate bill 1581 9
    Senate bill 1679 28
    Snyder, Hon. John W., Secretary of the Treasury, letter to, from Senator Murray, and reply thereto by Mr. Snyder, in re proposal that income-tax deductions be used as incentives for certain income groups to join voluntary health insurance programs 536
Olsen, John H., past president, American Protestant Hospital Association, insertions of:
  Crain, Kenneth C., article by, which appeared in Hospital Management, January 1949, entitled "To the Congress of the United States—A Brief on Compulsory Health Insurance Under Federal Legislation" 470
  Life Insurance Association of America, New York, N. Y., report of January 6, 1949, A Survey of Accident and Health Coverage in the United States as of December 31, 1947 491
Smith, Rt. Rev. Msgr. George Lewis, president, Catholic Hospital Association of the United States and Canada, insertion of: National Catholic Welfare Conference and National Conference of Catholic Charities, joint statement of, entitled "A Voluntary Approach to a National Health Program" 503
Thomas, Hon. Elbert D., a United States Senator from the State of Utah, statement of 77

NATIONAL HEALTH PROGRAM OF 1949

MONDAY, MAY 23, 1949

United States Senate,
Subcommittee on Health of the
Committee on Labor and Public Welfare,
Washington, D. C.

The subcommittee met, pursuant to call, at 10 a. m., in the committee hearing room, Senator James E. Murray (chairman) presiding.

Present: Senators Murray, Pepper, and Taft.

Also present: Senator Hill.

Senator Murray. The hearing will come to order. The Subcommittee on Health is today beginning hearings on four bills. Each of them has to do with some or several aspects of a subject which is of utmost importance to this country, the health and physical well-being of its people.

Today and tomorrow we hope to gain from the leading sponsors of these bills, and from individuals they have designated, a clear understanding of what each bill proposes to do and of how it would operate. Thereafter, through hearings scheduled to run through the month of June, we will receive testimony on these bills from interested organizations. It is our hope that such testimony will be informative, constructive, and to the point.

The entire subcommittee is in agreement in its desire that these hearings shall be both thorough and expeditious. We want to hear all points of view, and we want to get all of the facts necessary to the formation of legislation which will be sound in its objectives and practical in its operations.

Despite our present differences of opinion as to the extent and the kind of health problems confronting us, even though we may disagree as to the methods of solving these problems, on some things we are unanimous. We agree that there is a problem and that it is our responsibility to find a solution.

With that in mind I know that I can expect the full cooperation of my colleagues in endeavoring to keep to our schedule and to see to it that both testimony and cross-examination are relevant to the subject matter of the business before us.

Our program these first 2 days calls for explanation of S. 1679, the National Health Insurance and Public Health Act, sponsored by Senators Thomas of Utah, Wagner, Pepper, Chavez, Taylor, McGrath, Humphrey, and myself. This will be undertaken by Senator Thomas and by Mr. Kingsley, Assistant Administrator of the Federal Security Administration.

Senators Taft and Donnell will then discuss S. 1581, the National Health Act of 1949, sponsored by Senators Taft, Donnell, and Smith of New Jersey.

Following their presentation, Senator Hill and Mr. Bugbee will discuss S. 1456, the Voluntary Health Insurance Act, sponsored by Senators Hill, O'Conor, Withers, Aiken, and Morse.

Then Senator Lodge will discuss his bill, S. 1106, the Medical Aid Act of 1949.

I should add at this point that neither titles III and V of S. 1679 or titles IV and V of S. 1581 will be considered by this subcommittee. They have been referred to Senator Hill's subcommittee and have been studied in connection with S. 614, S. 522, and other bills relating to expansion of hospital facilities and public health service.

(S. 1106, S. 1456, S. 1581, S. 1679 are as follows:)

[S. 1106, 81st Cong., 1st sess.]

A BILL To amend the Public Health Service Act, as amended, so as to provide assistance to the States in furnishing certain medical aid to needy and other individuals

Be it enacted by the Senate and House of Representatives of the United States of America in Congress assembled, That this Act may be cited as the "Medical Aid Act of 1949."

SEC. 2. The Public Health Service Act (consisting of titles I to VI, inclusive, of the Act of July 1, 1944) is hereby amended by adding at the end thereof the following new title:

"TITLE VII—GRANTS TO STATES FOR MEDICAL AID

"APPROPRIATIONS

"SEC. 701. For the purpose of enabling the several States to provide or to assist in providing certain medical services and medicines, which are standardized in their nature but which, because of their high costs, are not used in many cases in which their use is desirable, there is hereby authorized to be appropriated for the fiscal year ending June 30, 1948, and for each fiscal year thereafter, such sums as may be necessary to carry out the provisions of this title. The sums made available under this section shall be used for making payments to States which have submitted, and had approved by the Surgeon General, State plans for furnishing medical aid.

"STATE PLANS FOR FURNISHING MEDICAL AID

"SEC. 702. (a) A State plan for furnishing medical aid must (1) provide that it shall be available to all political subdivisions of the State; (2) provide for financial participation by the State; (3) provide for the designation of the State health agency to administer the plan; (4) provide that the State health agency will make such reports, in such form and containing such information, as the Surgeon General may from time to time require, and comply with such provisions as the Surgeon General may from time to time find necessary to assure the correctness and verification of such reports; and (5) provide such methods of administration of the State plan, including methods relating to the establishment and maintenance of personnel standards on a merit basis (except that the Surgeon General shall exercise no authority with respect to the selection, tenure of office, or compensation of any individual employed in accordance with such methods) as the Surgeon General prescribes by regulation under section 705 of this title.

"(b) The Surgeon General shall approve any plan which fulfills the conditions specified in subsection (a), except that he shall not approve any plan which imposes as a condition of eligibility for medical aid a residence requirement which denies aid with respect to any person who has lived in the State for three months immediately preceding the application for such aid.

"PAYMENT TO STATES

"SEC. 703. (a) From the sums appropriated under section 701, the Secretary of the Treasury shall pay to each State which has an approved plan for medical aid, for each quarter, beginning with the quarter commencing July 1, 1947, an amount, which shall be used exclusively for carrying out the State plan, equal to one-half of the total of the sums expended during such quarter under such plan.

"(b) The method of computing and paying such amounts shall be as follows:

(1) The Surgeon General shall, prior to the beginning of each quarter, estimate the amount to be paid to the State for such quarter under the provisions of subsection (a), such estimate to be based on (A) a report filed by the State containing its estimate of the total sum to be expended in such quarter in accordance with the provisions of such subsection and stating the amount appropriated or made available by the State and its political subdivisions for such expenditures in such quarter, and if such amount is less than one-half of the total sum of such estimated expenditures, the source or sources from which the difference is expected to be derived, and (B) such other investigation as the Surgeon General may find necessary.

"(2) The Surgean General shall then certify to the Secretary of the Treasury the amount so estimated by the Surgeon General, reduced or increased, as the case may be, by any sum by which he finds that its estimate for any prior quarter was greater or less than the amount which should have been paid to the State for such quarter, except to the extent that such sum has been applied to make the amount certified for any prior quarter greater or less than the amount estimated by the Surgeon General for such prior quarter.

"(3) The Secretary of the Treasury shall thereupon, through the fiscal service of the Treasury Department and prior to audit or settlement by the General Accounting Office, pay to the State, at the time or times fixed by the Surgeon General, the amount so certified.

"OPERATION OF STATE PLANS

"Sec. 704. In the case of any State plan for medical aid which has been approved by the Surgeon General, if the Surgeon General, after reasonable notice and opportunity for hearing to the State health agency administering such plan, finds—

"(1) that the plan has been so changed as to impose any residence requirement prohibited by section 702 (b), or that in the administration of the plan any such prohibited requirement is imposed, with the knowledge of such State health agency, in a substantial number of cases; or

"(2) that in the administration of the plan there is a failure to comply substantially with any provision required by section 702 (a) to be included in the plan; the Surgeon General shall notify such State health agency that further payments will not be made to the State until the Surgeon General is satisfied that such prohibited requirement is no longer so imposed, and that there is no longer any such failure to comply. Until he is so satisfied he shall make no further certification to the Secretary of the Treasury with respect to such State.

"REGULATIONS

"Sec. 705. The Surgeon General shall have authority to prescribe the rules and regulations necessary to carry out the provisions of this title, including the expansion or restriction of the services and drugs falling within the term 'medical aid' as defined in section 706 (a). All rules, regulations, and amendments thereto with respect to grants to States under this title shall be made after consultation with a conference of the State health authorities. Insofar as practicable, the Surgeon General shall obtain the agreement, prior to the issuance of any such rules, regulations, or amendments, of the State health authorities.

"DEFINITIONS

"Sec. 706. As used in this title—

"(a) (1) The term 'medical aid' means making available, free to such persons as may require them, X-ray services, laboratory diagnostic services, respirators, and any drug which is of substantial, accepted, and specific value in the treatment or prevention of pneumonia, streptococcus infection, diabetes, pernicious anemia and other anemias, congestive heart failure, glandular and nervous disorders, nutritional deficiency, typhoid fever, and such other infectious or chronic diseases as the Surgeon General may from time to time prescribe.

"(b) The term 'State' means the several States and the District of Columbia."

Sec. 3. Section 1 of the Public Health Service Act, as amended, is amended to read as follows:

"SECTION 1. Title I to VII, inclusive, of this Act may be cited as the 'Public Health Service Act'."

SEC. 4. The Act of July 1, 1944, as amended, is further amended by changing the number of title VII to title VIII and by changing the numbers of sections 701 to 712, inclusive, and references thereto, to sections 801 to 812, respectively.

[S. 1456, 81st Cong., 1st sess.]

A BILL To authorize grants to enable the States to survey, coordinate, supplement, and strengthen their existing health resources so that hospital and medical care may be obtained by all persons

Be it enacted by the Senate and House of Representatives of the United States of America in Congress assembled, That this Act may be cited as the "Voluntary Health Insurance Act".

SEC. 2. The Public Health Service Act (consisting of titles I to VI, inclusive, of the Act of July 1, 1944 (58 Stat. 682), is hereby amended by adding at the end thereof the following new title:

"TITLE VII—HOSPITAL AND MEDICAL CARE

"PART A—DECLARATION OF PURPOSE; DEFINITIONS

"SEC. 701. The purpose of this title is to make a high quality of hospital and medical care available to all persons in each State by (a) strengthening and coordinating existing health resources within the State, (b) encouraging and stimulating voluntary enrollment in prepayment plans for hospital and medical care, with emphasis on employer participation and on making such protection available to persons in rural areas, and (c) providing protection to persons financially unable to pay all or part of subscription charges for prepayment of hospital and medical care (hereinafter referred to as 'subscription charges').

"DEFINITIONS

"SEC. 702. For the purposes of this title—

"(a) The term 'hospital and medical care" means surgical, obstetrical and medical services, furnished in a hospital, and hospital services incident thereto, not in excess of sixty days in any year, and including diagnostic and out-patient clinic services furnished in a hospital or a diagnostic clinic.

"(b) The term 'hospital' includes any hospital which has an average patient stay of less than thirty days or any diagnostic clinic, which conforms to standards of maintenance and operation established by the State.

"(c) The term 'voluntary prepayment plan' means any nonprofit or other corporation or association furnishing protection against the cost of hospital and medical care on a voluntary prepayment basis.

"(d) The term 'nonprofit prepayment plan' means any corporation or association, no part of the net earnings of which inures or may lawfully inure to the benefit of any private shareholder or individual, furnishing protection against the cost of hospital and medical care on a voluntary prepayment basis.

"(e) The term 'State' includes Alaska, Hawaii, Puerto Rico, and the District of Columbia.

"PART B—HOSPITAL AND MEDICAL CARE UNDER STATE PLANS

"APPROPRIATION

"SEC. 711. For the purpose of enabling each State to carry out the purposes set forth in section 701, as far as practicable under the conditions in such State, there is hereby authorized to be appropriated for each fiscal year a sum sufficient to carry out the purposes of this part. The sums made available under this section shall be used for making payments to States which have submitted, and had approved by the Surgeon General of the Public Health Service, State plans for carrying out the purposes set forth in section 701.

"GENERAL REGULATIONS

"SEC. 712. Within six months after the enactment of this title, the Surgeon General, with the approval of the Federal Hospital and Medical Care Council and the Adminstrator, shall by general regulation prescribe—

"(a) the general manner in which the State agency shall determine eligibilty of persons unable to pay subscription charges for prepayment of hospital and medical care;

"(b) the general types of hospital and medical care which may be provided;

"(c) general standards for particpation under this title of voluntary prepayment plans for hospital and medical care;

"(d) general standards for particpation under this title of nonprofit prepayment plans;

"(e) the general manner in which the State agency shall stimulate and assist in enrolling the population in voluntary prepayment plans for hospital and medical care; and

"(f) general methods of administration of the State plan by the designated State agency, subject to the limitations set forth in section 713 (a) (7).

"STATE PLANS

"SEC. 713. (a) Any State desiring to take advantage of this part may submit a State plan which must—

"(1) provide that it shall be in effect in all political subdivisions of the State, and if adminstered by them, be mandatory upon them;

"(2) provide for over-all financial participation by the State in a total amount at least equal to 50 per centum of that portion of the total amount expended under the State plan during any quarter in furnishing hospital and medical care to persons unable to pay subscription charges, for which payment to the State is not made under section 714;

"(3) designate a single State agency (which may be the State agency designated to adminster part C of the Hospital Survey and Construction Act in such State) as the sole agency for the administration of the State plan;

"(4) provide for the designation of a State hospital and medical care council of eleven members consisting of the head of the State agency administering the State plan, who shall serve as chairman ex officio, and ten appointed members (who at the time of appointment are members of Hospital and Medical Care Authorities created under paragraph (11)), four of whom shall be persons who are outstanding in fields pertaining to hospital and medical care, at least two of whom shall be doctors of medicine and two of whom shall be hospital administrators, two members shall be persons experienced in the administration of voluntary prepayment plans for hospital and medical care, and four members shall be appointed to represent the consumers of hospital and medical care and shall be persons familiar with the need for hospital and medical care in rural or urban areas;

"(5) contain satisfactory evidence that the State agency designated in accordance with paragraph (3) hereof will have authority to carry out such plan in conformity with this part;

"(6) give adequate assurance that Federal funds will be used to supplement total payments being made by the State and its political subdivisions for the purposes described in the State plan and not as a substitute for such payments;

"(7) provide such methods of administration of the State plan, including methods relating to the establishment and maintenance of personnel standards on a merit basis (except that the Surgeon General shall exercise no authority with respect to the selection, tenure of office, or compensation of any individual employed in accordance with such methods), as the Surgeon General may by regulation prescribe;

"(8) provide that the State agency will make such reports in such form and containing such information as the Surgeon General may from time to time reasonably require, and give the Surgeon General, upon demand, access to the records upon which such information is based;

"(9) provide safeguards which restrict the use or disclosure of information concerning recipients to purposes directly connected with the administration of hospital and medical care under the State plan;

"(10) provide that determination of eligibility shall be made, insofar as possible, in advance of the need for hospital and medical care; that the individual shall not be identified as a person accepting assistance at the time of receiving care; and that the individual shall not be provided a separate grade or classification of care because of his accepting assistance;

"(11) provide for the creation of a Hospital and Medical Care Authority within each of the regions into which the State has been or will be divided under the Hospital Survey and Construction Act, or by other means, composed of persons residing within the region which shall include representatives of nongovernment organizations or groups, and of State and local agencies, concerned with the utilization of hospitals, including representatives of medical associations, hospital associations, voluntary prepayment plans for hospital and medical care, and including representatives of the consumers of hospital and medical care selected from persons familiar with the need for such care in urban or rural areas, to cooperate with and assist the State agency in carrying out such State plan, subject to the provisions of paragraph (3) above;

"(12) provide that such regional Hospital and Medical Care Authority shall encourage coordination of all health facilities and services in the region, both voluntary and government, and recommend means for their effective utilization in making hospital and medical care available to all persons in the regions;

"(13) provide for the issuance from time to time by the appropriate agency or agencies designated by the State of service cards of participating nonprofit prepayment plans for hospital and medical care to all persons who are certified as unable to pay all or part of the subscription charges of prepayment plans for such care, whether or not in immediate need of such care, which will entitle such persons to needed hospital and medical care;

"(14) provide for furnishing such types of hospital and medical care to persons holding such service cards as may be required by regulations prescribed by the Surgeon General under section 712;

"(15) provide for satisfactory contracts or arrangements so that following the admission of each such qualified person to a hospital such nonprofit prepayment plan will accept liability for payment for all essential services in the same manner as in the case of its regular subscribers, and that hospital and medical care under such contracts or arrangements will be paid for by such prepayment plan on a basis mutually agreeable to participating doctors and hospitals and the State agency or regional authority concerned;

"(16) provide for payment by the State agency of the full amount of payments for hospital and medical care by such nonprofit prepayment plans plus such reasonable administrative expenses as may be mutually agreed upon;

"(17) provide methods of determining eligibility of persons to receive service cards, in accordance with regulations prescribed by the Surgeon General under section 712, and methods for obtaining partial reimbursement from such persons according to their financial ability to pay subscription charges;

"(18) provide for a survey of existing diagnostic facilities and a plan for meeting the need for any additional necessary diagnostic services and making such services available to all persons in the State;

"(19) provide for a survey of existing facilities, services, and financing for the care of mental, tuberculous, and chronic-disease and other patients hospitalized for long periods of time, and a plan for meeting the need for any additional facilities, services, and financing, in order to provide proper care for such patients;

"(20) provide for a survey of areas in the State which are unable to attract practicing physicians, and recommend methods for encouraging physicians to practice medicine in such needy areas;

"(21) provide that if any person drawing unemployment compensation is enrolled in a participating voluntary prepayment plan for hospital and medical care, pro rata subscription charges in such plan for such person and his dependents shall be paid, out of funds available for hospital and medical care, for the period of time during which any such person is in receipt of unemployment compensation, such payment of subscription charges to be by way of direct payment to the plan either for the period of unemployment or, if subscription charges have been paid in advance, by way of extension of the period of protection of the plan for the period of unemployment, as may be prescribed by State law;

"(22) provide for pay-roll deduction of subscription charges in voluntary prepayment plans for hospital and medical care for each employee (and his dependents) of the State or political subdivision thereof who requests such deduction;

"(23) provide for a survey of existing enrollment in participating voluntary prepayment plans and development of a plan for stimulating and encouraging enrollment in such plans by all persons able to pay subscription charges, with emphasis on employer participation and enrollment of persons in rural areas; and

"(24) provide that the State agency will from time to time review the State plan and submit to the Surgeon General any modifications thereof which it considers necessary.

"(b) The Surgeon General shall approve any State plan and any modification thereof which fulfills the conditions specified in subsection (a). If any such plan or modification thereof shall have been disapproved by the Surgeon General for failure to comply with subsection (a), the Federal Hospital and Medical Care Council shall, upon request of the State agency, afford it an opportunity for hearing. If such Council determines that the plan or modification complies with the provisions of such subsection, the Surgeon General shall thereupon approve such plan or modification.

"PAYMENT TO STATES

"SEC. 714. (a) From the sums appropriated therefor, the Secretary of the Treasury shall pay to each State which has an approved plan under this part, for each quarter, beginning with the first quarter commencing after the date of enactment of this Act, (1) an amount, which shall be used exclusively as hospital and medical care to persons unable to pay subscription charges, and including administrative expenses of the voluntary prepayment plan making such payments as required by section 713 (a) (15), equal to the Federal percentage (as defined in section 721) of the total sums expended during such quarter as hospital and medical care to persons unable to pay subscription charges, including such administrative expenses, under the State plan with respect to each such person; and (2) an amount equal to one-half of the total of the sums expended during such quarter as found necessary by the Surgeon General for the proper and efficient administration of the State plan, including expenditures required by section 713 (a) (18), (19), (20), (21), and (23), which amount shall be used for paying the costs of administering the State plan or for hospital and medical care to persons unable to pay subscription charges, or both, and for no other purpose.

"(b) The method of computing and paying such amounts shall be as follows:

"(1) The Surgeon General shall, prior to the beginning of each quarter, estimate the amount to be paid to the State for such quarter under the provisions of subsection (a), such estimate to be based on (A) a report filed by the State containing its estimate of the total sum to be expended in such quarter in accordance with the provisions of such subsection, and stating the amount appropriated or made available by the State and its political subdivisons for such expenditures in such quarter, and if such amount is less than the State's proportionate share of the total sum of such estimated expenditures, the source or sources from which the difference is expected to be derived, (B) records showing the number of persons in the State unable to pay subscription charges, and (C) such other investigation as the Surgeon General may find necessary.

"(2) The Surgeon General shall then certify to the Secretary of the Treasury the amount so estimated by the Surgeon General, (A) reduced or increased, as the case may be, by any sum by which he finds that his estimate for any prior quarter was greater or less than the amount which should have been paid to the State under subsection (a) for such quarter, and (B) reduced by a sum equivalent to the pro rata share to which the United States is equitably entitled, as determined by the Surgeon General, of the net amount recovered during any prior quarter by the State or any political subdivision thereof with respect to hospital and medical care furnished under the State plan; except that such increases or reductions shall not be made to the extent that such sums have been applied to make the amount certified for any prior quarter greater or less than the amount estimated by the Surgeon General for such prior quarter: *Provided*, That any part of the amount recovered from the estate of a deceased recipient which is not in excess of the amount expended by the State or any political subdivision thereof for the funeral expenses of the deceased shall not be considered as a basis for reduction under clause (B) of this paragraph.

"(3) The Secretary of the Treasury shall thereupon, through the Fiscal Service of the Treasury Department and prior to audit or settlement by the General Accounting Office, pay to the State, at the time or times fixed by the Surgeon General, the amount so certified.

"PART C—MISCELLANEOUS

"THE FEDERAL PERCENTAGE

"SEC. 721. For the purposes of this title—

"(a) the Federal percentage for any State shall be 100 per centum less that percentage which bears the same ratio to 50 per centum as the per capita income of such State bears to the per capita income of the continental United States (excluding Alaska), except that (1) the Federal percentage shall in no case be more than 75 per centum or less than 33⅓ per centum, and (2) the Federal percentage for Alaska and Hawaii shall be 50 per centum each, and the Federal percentage for Puerto Rico shall be 75 per centum; and

"(b) the Federal percentages shall be promulgated by the Surgeon General between July 1 and August 31 of each even-numbered year, on the basis of the average of the per capita incomes of the States and of the continental United States for the three most recent consecutive years for which satisfactory data are available from the Department of Commerce. Such promulgation shall be conclusive for each of the two fiscal years in the period beginning July 1 next succeeding such promulgation: *Provided*, That the Surgeon General shall promulgate such percentages as soon as possible after the enactment of this title, which promulgation shall be conclusive for the fiscal year ending June 30, 1951.

"OPERATION OF STATE PLANS

"SEC. 722. In the case of any State plan under this part which has been approved by the Surgeon General, if the Surgeon General, after reasonable notice and opportunity for hearing to the State agency administering such plan, finds that in the administration of the plan there is a failure to comply substantially with any provision required by section 713 (a) to be included in the plan, the Surgeon General shall notify such State agency that further payments will not be made to the State until the Surgeon General is satisfied that there is no longer any such failure to comply. Until he is so satisfied he shall make no further certification to the Secretary of the Treasury with respect to such State.

"ADMINISTRATION: FEDERAL HOSPITAL AND MEDICAL CARE COUNCIL

"SEC. 723. (a) The Surgeon General is authorized to make such administrative regulations and perform such other functions as he finds necessary to carry out the provisions of this title. Any such regulations shall be subject to the approval of the Administrator.

"(b) In administering this title, the Surgeon General shall consult with a Federal Hospital and Medical Care Council consisting of the Surgeon General, who shall serve as chairman ex officio, and ten members appointed by the Administrator. Four of the ten appointed members shall be persons who are outstanding in fields pertaining to hospital and medical care, at least two of whom shall be doctors of medicine and two of whom shall be hospital administrators, two members shall be persons experienced in the administration of voluntary prepayment plans for hospital and medical care, and the other four members shall be appointed to represent the consumers of hospital and medical care and shall be persons familiar with the need for hospital and medical care in rural or urban areas. Each appointed member shall hold office for a term of five years, except that any member appointed to fill a vacancy occurring prior to the expiration of the term for which his predecessor was appointed shall be appointed for the remainder of such term, and the terms of office of the members first taking office shall expire, as designated by the Administrator at the time of appointment, two at the end of the first year, two at the end of the second year, two at the end of the third year, two at the end of the fourth year, and two at the end of the fifth year after the date of appointment. An appointed member shall not be eligible to serve continuously for more than two terms but shall be eligible for reappointment if he has not served immediately preceding his reappointment. The Council is authorized to appoint such special advisory and technical committees as may be useful in carrying out its functions. Appointed Council members and members of advisory or technical committees, while serving on business of the Council, shall receive compensation at rates fixed by the Administrator, but not exceeding $25 per day, and shall also be entitled to receive an allowance for actual and necessary travel and subsistence expenses while so serving away from their places of residence. The Council shall meet as frequently as the Surgeon General deems necessary, but not less than once each year. Upon request by four or more members, it shall be the duty of the Surgeon General to call a meeting of the Council.

"(c) In administering the provisions of this title, the Surgeon General, with the approval of the Administrator, is authorized to utilize the services and facilities of any executive department in accordance with an agreement with the head thereof. Payment for such services and facilities shall be made in advance or by way of reimbursement, as may be agreed upon between the Administrator and the head of the executive department furnishing them.

"STATE CONTROL

"SEC. 724. Except as otherwise specifically provided, nothing in this title shall be construed as conferring upon any Federal officer or employee the right to exercise any supervision or control over the administration, personnel maintenance, or operation of any hospital utilized for furnishing hospital and medical care pursuant to the provisions of this title.

"FEDERAL PAY-ROLL DEDUCTIONS FOR HOSPITAL AND MEDICAL CARE SUBSCRIPTION CHARGES

"SEC. 725. Upon the direction of any officer or employee of the Government of the United States, including members of the Armed Forces, requesting the Government to deduct from the salary of such person a fixed sum or percentage to be paid to any voluntary prepayment plan, said sum or percentage shall be deducted as requested and paid as directed. 'Officer or employee of the Government of the United States' as used herein shall include any officer or employee of any corporation the stock of which is wholly owned by the Government of the United States, as well as any officer or employee of any department, bureau, agency, or division of the Government of the United States.

"SEC. 726. Nothing in this title shall modify obligations assumed by the Federal Government under other statutes for the hospital and medical care of veterans or other presently authorized recipients of hospital and medical care under Federal programs."

SEC. 3. Section 1 of the Public Health Service Act is amended to read as follows:

"SECTION 1. Titles I to VII, inclusive, of this Act may be cited as the 'Public Health Service Act'."

SEC. 4. The Act of July 1, 1944 (58 Stat. 682), as amended, is hereby further amended by changing the number of title VII to title VIII and by changing the numbers of sections 701 to 714, inclusive, and references thereto, to sections 801 to 814, respectively.

[S. 1581, 81st Cong., 1st sess.]

A BILL To coordinate the health functions of the Federal Government in a single agency; to authorize grants to States for extending and improving the provision of medical, hospital, and dental services; to authorize grants to States for providing health examinations for school children and medical and dental treatment in certain cases; to amend the Hospital Survey and Construction Act (title VI of the Public Health Service Act) to extend its duration and provide greater financial assistance in the construction of hospitals; to amend the Public Health Service Act to authorize grants to States and political subdivisions in the development and maintenance of local public health units; to authorize studies and grants for increasing available manpower in the health professions; and for other purposes

Be it enacted by the Senate and House of Representatives of the United States of America in Congress assembled, That this Act may be cited as the "National Health Act of 1949."

SEC. 2. (a) The Congress hereby finds and declares—

(1) that health and medical functions are widely scattered through many agencies in the Federal Government with resultant confusion and duplication of effort, and that because of this diffuse organization State health administrators and other State officials find it necessary to submit plans and budgets to numerous Federal officials responsible for health programs authorized under a large number of unrelated statutes; and

(2) that there are inadequacies in the distribution of public health services and of medical, dental, and hospital services in the United States, and

a shortage in professional personnel who provide such services, with the result that some persons are unable to secure such services to an adequate degree.

(b) The Congress hereby further declares that it is the policy of the United States—

(1) to centralize in a single agency the activities of the Federal Government relating to health;

(2) to aid the States, through consultative services and grants-in-aid, in extending the provisions of medical, hospital, and dental services without discrimination to all individuals unable to pay the whole cost thereof, and in improving the manner in which such services are distributed; in providing medical and dental examinations to school children; and in expanding available hospital, clinical, and public-health facilities;

(3) to make provision for a study of training facilities and manpower requirements in the health professions and for temporary payments to medical schools for maintaining and increasing enrollment; and

(4) to make provision for voluntary deductions from the salaries of Federal employees of premiums directed by them to be paid to voluntary nonprofit health insurance funds.

TITLE I—NATIONAL HEALTH AGENCY

CREATION OF AGENCY

SEC. 101. (a) There is hereby created in the executive branch of the Government an independent agency to be known as the National Health Agency (hereinafter called the "Agency"), which shall be administered by a National Health Administrator (hereinafter called the "Administrator"), who shall be appointed by the President, by and with the advice and consent of the Senate, and who shall receive compensation at the rate of $15,000 per annum.

(b) The Administrator shall cause an official seal to be made for the Agency of such device as the President shall approve, and judicial notice shall be taken thereof.

(c) The Administrator, who shall engage in no other business, vocation, or employment, shall be a citizen of the United States and a doctor of medicine licensed to practice in one or more of the States who previously shall have demonstrated outstanding ability in the fields of medicine and administration.

PURPOSE OF AGENCY

SEC. 102. (a) It shall be the purpose of the Agency to aid and foster progress throughout the Nation in the fields of health and medicine.

(b) To carry out the purpose of subsection (a) the Agency shall—

(1) encourage the development throughout the Nation of health services and facilities;

(2) advise and cooperate with other agencies and departments of the Federal Government, and with State governments and agencies, and with private agencies functioning in the field of health;

(3) collect and analyze statistics and make studies, investigations, and reports on conditions, problems, and needs in the field of health in the United States and in other countries, and disseminate and make available information in this field;

(4) make reports and recommendations with respect to the most efficient policies and methods for the promotion of health and related services; and

(5) carry out such specific duties as may be entrusted to it by this and subsequent Acts of Congress, and exercise general supervision over the agencies transferred to it pursuant to section 103.

(c) Nothing in this title shall be deemed to transfer to the Agency any powers, functions, or duties exercised by the armed services or the Veterans' Administration.

TRANSFERS TO AGENCY

SEC. 103. (a) Upon the effective date of this title, as provided in section 109, there are hereby transferred to the Agency the following agencies, and their functions, powers, and duties: The Public Health Service, Saint Elizabeths Hospital, and the Food and Drug Administration.

(b) Upon the effective date of this title, as provided in section 109, there are hereby transferred to the Agency the functions and duties of the Children's Bureau in the Social Security Administration concerned with the administration of title V, parts 1 and 2, of the Social Security Act, as amended, and the functions and duties of the Social Security Administration pertaining to research in the field of health.

(c) Upon the transfers provided for in subsections (a) and (b) all laws relating to any agency or functions transferred shall, insofar as such laws are not inapplicable, remain in full force and effect. Any transfer of personnel pursuant to this title shall be without change in classification or compensation, except that this requirement shall not operate to prevent the adjustment of classification or compensation to conform to the duties which may be assigned to such transferred personnel. All orders, rules, regulations, permits, or other privileges made, issued, or granted by any agency, or in connection with any function, so transferred, and in effect at the time of the transfer, shall, until modified, superseded, or repealed, continue in effect to the same extent as if such transfer had not occurred. No suit, action, or other proceeding lawfully commenced by or against any agency or any officer of the United States acting in his official capacity shall abate by reason of any transfer made pursuant to this title, but the court, on motion or supplemental petition filed at any time within twelve months after such transfer takes effect, showing necessity for a survival of such suit, action, or other proceeding to obtain a settlement of the questions involved, may allow the same to be maintained by or against the appropriate agency or officer of the United States.

(d) All personnel and property (including office equipment and records) of the agencies which are transferred under subsection (a) shall be transferred to the Agency.

(e) The personnel primarily concerned with, and the property (including office equipment and records) used in connection with, the functions transferred to the Agency under subsection (b) shall be transferred to the Agency.

(f) So much of the unexpended balances of the appropriations, allocations, or other funds available or to be made available for the use of the agencies and of officers and employees of the agencies transferred, and of agencies and officers and employees of agencies some or all of whose functions are transferred under this section, as the Director of the Bureau of the Budget with the approval of the President shall determine, shall be transferred to the Agency, but only for the use of such agency or function herein transferred to the Agency for whose use such appropriation, allocation, or other fund was originally provided. In determining the amount to be transferred, the Director of the Bureau of the Budget may include an amount to provide for the liquidation of obligations incurred against such appropriations or other funds prior to the transfer.

(g) The Director of the Bureau of the Budget is hereby authorized and directed to make a study of the activities of the several departments and agencies of the Federal Government with a view to determining whether any activities of such departments and agencies relating to health, but not transferred to the Agency by this title, should, in the interests of economy and efficiency of administration, be transferred to the Agency; and to complete such study and report the results thereof to the Congress on or before December 31, 1949.

CONSTITUENT UNITS

SEC. 104. (a) The Agency shall be composed of the following constituent units: (1) The Office of the Administrator; (2) the Public Health Service, which in turn shall assume the administration of Saint Elizabeths Hospital; (3) the Office of Medical, Dental, and Hospital Services; (4) the Office of Maternal and Child Health; (5) the Food and Drug Administration; and (6) such other constituent units as the Administrator finds necessary.

(b) The organization of the Food and Drug Administration shall remain unchanged except insofar as it may conflict with specific provisions of this title. The Surgeon General of the Public Health Service shall be appointed as provided in section 204 of the Public Health Service Act. The heads of the other constituent units of the Agency provided herein shall be appointed by the Administrator.

(c) The Director of the Office of Medical, Dental, and Hospital Services shall be a doctor of medicine licensed to practice medicine in one or more of the States, who previously shall have demonstrated outstanding ability in the fields of medicine and administration.

(d) Within the Office of Maternal and Child Health there shall be an Advisory Council on Maternal and Child Health to be appointed by the Administrator, which shall advise and consult with the head of the Office of Maternal and Child Health in the formulation and administration of the medical and technical activities of said Office. Such council shall be composed of eight members, at least three of whom shall be doctors of medicine who are specialists in obstetrics or pediatrics. Each member shall hold office for a term of four years, except that any member appointed to fill a vacancy occurring prior to the expiration of the term for which his predecessor was appointed shall be appointed for the remainder of such term, and except that the first terms of the original members shall expire, as designated by the Administrator at the time of appointment, two at the end of one year, two at the end of two years, two at the end of three years, and two at the end of four years, after the date of appointment. At the time of appointment the Administrator shall designate one member to be chairman of the council.

Each member of the Advisory Council on Maternal and Child Health, while attending meetings of such council or while otherwise serving pursuant to this section, shall be entitled to receive compensation at a rate to be fixed by the Administrator, but not to exceed $50 per diem, and shall also be entitled to receive an allowance for actual and necessary traveling and subsistence expenses while so serving away from his place of residence.

AUTHORIZATION OF EXPENDITURES

SEC. 105. The Administrator is authorized to make expenditures (including expenditures for personal services and rent at the seat of government and elsewhere, for lawbooks, books of reference and periodicals, and for printing and binding) as may be necessary to carry out the provisions of this title, and as may be provided for by the Congress from time to time.

REPORT TO CONGRESS

SEC. 106. The Administrator shall make at the close of each fiscal year a report in writing to Congress and the President giving an account of all moneys received and disbursed by him and the Agency, describing the work done by the Agency, and making such recommendations as he shall deem necessary for the effective performance of the duties and purposes of the Agency.

AUTHORIZATION OF APPROPRIATIONS FOR ADMINISTRATIVE EXPENSES

SEC. 107. There are authorized to be appropriated for the administrative expenses of the Agency, including such expenses as are described in section 105, for the fiscal year ending June 30, 1950, and for each year thereafter, the sums necessary for such purposes.

ORGANIZATION STUDY

SEC. 108. The Administrator shall make a study of the organization and staffing of the Agency and of its constituent units, and, within one year after the effective date of this title, shall report to the Congress his findings and recommendations for promoting the more efficient and effective operation of the Agency.

EFFECTIVE DATE

SEC. 109. This title shall take effect July 1, 1949. The Administrator may be appointed by the President, and his appointment confirmed by the Senate, at any time after the enactment of this title, but such appointment shall not become effective until July 1, 1949.

TITLE II—GRANTS IN AID FOR EXTENDING MEDICAL, HOSPITAL, AND DENTAL SERVICES TO INDIVIDUALS UNABLE TO PAY THE WHOLE COST THEREOF; AND FOR OTHER PURPOSES

PART A—MEDICAL, HOSPITAL, AND DENTAL SURVEY

AUTHORIZATION OF APPROPRIATION FOR SURVEY

SEC. 201. In order to assist the States in making surveys preparatory to carrying out the purposes of part B of this title, there is hereby authorized to be appropriated the sum of $5,000,000, to remain available until expended. The sums appropriated under this section shall be used for making payments to

States which have submitted, and had approved by the Director of the Office of Medical, Dental, and Hospital Services (hereinafter called the "Director"), applications as provided in section 202, to assist such States in making the State-wide surveys required in section 212 (a) (11).

STATE APPLICATION

SEC. 202. (a) To be approved, a State application for funds for carrying out the purposes of section 201 must—

(1) designate the State health agency as the sole agency for carrying out, or supervising the carrying out of, such purposes;

(2) provide for the designation of a State advisory council, which shall include representatives of nongovernment organizations or groups, and of State agencies, concerned with the provision of medical, dental, hospital, or public health services, including representatives of the users of such services selected from among persons familiar with the need for such services in urban or rural areas, to consult with the State agency in carrying out such purposes;

(3) provide for making a survey in accordance with section 212 (a) (11) containing all information required by the Director, and for developing a program in accordance with section 212 (a) and with regulations prescribed under section 215 (a); and

(4) provide that the State agency will make such reports, in such form and containing such information as the Director may from time to time reasonably require, and give the Director, upon demand, access to the records on which such reports are based.

(b) The Director shall approve any application for funds which complies with the provisions of subsection (a).

ALLOTMENTS TO STATES FOR SURVEYS

SEC. 203. (a) Each State for which a State application under section 202 has been approved shall be entitled to an allotment of such proportion of any appropriation made pursuant to section 201 as its population bears to the population of all the States, and within such allotment it shall be entitled to receive 50 per centum of its expenditures in carrying out the purposes of section 201 in accordance with its application: *Provided*, That no such allotment to any State shall be less than $20,000. The Director shall from time to time estimate the sum to which each State will be entitled under this section during such ensuing period as he may determine, and shall thereupon certify to the Secretary of the Treasury the amount so estimated, reduced or increased, as the case may be, by any sum by which the Director finds that his estimate for any prior period was greater or less than the amount to which the State was entitled for such period. The Secretary of the Treasury shall thereupon, prior to audit or settlement by the General Accounting Office, pay to the State, at the time or times fixed by the Director, the amount so certified.

(b) Any funds paid to a State under this section and not expended for the purposes for which paid shall be repaid to the Treasury of the United States.

PART B—MEDICAL, DENTAL, AND HOSPITAL SERVICES

AUTHORIZATION OF APPROPRIATION

SEC. 211. In order to assist the States to provide general health, hospital, medical, and dental services for families and individuals unable to pay the whole cost thereof, and for other purposes, in accordance with the provisions of this part, there is hereby authorized to be appropriated for the fiscal year ending June 30, 1950, the sum of $150,000,000; for the fiscal year ending June 30, 1951, the sum of $200,000,000; and for each of the three succeeding fiscal years, the sum of $300,000,000; and there are further authorized to be appropriated for such purposes the sums provided in section 213 (b). The sums appropriated pursuant to this section shall be used for making payments to the States which have submitted, and had approved by the Director, State plans in accordance with the provisions of this part. During and after said five years Congress shall review the program and determine the amount to be authorized thereafter.

STATE PLAN

SEC. 212. (a) Any State desiring to take advantage of this part may submit a State plan for carrying out its purposes. Such plan must—

(1) designate the State health agency as the sole agency for the administration of the plan or for supervising the administration of the plan: *Provided*, That nothing in this part shall be construed as prohibiting a State plan from providing such administrative arrangements involving other State agencies as may be necessary to prevent duplication of existing administrative functions, particularly in regard to the determination of eligibility for the services provided under this part;

(2) provide such methods of administration (including methods relating to the establishment and maintenance of personnel standards on a merit basis, except that the Director shall exercise no authority with respect to the selection, tenure of office, and compensation of any individual employed in accordance with such methods) as are found by the Director to be necessary for the proper and efficient operation of the plan;

(3) provide for the designation by the Governor of a State medical, dental, and hospital advisory council, which shall include representatives of nongovernment organizations or groups, and of State agencies, concerned with the administration, provision, or utilization of health, medical, dental, or hospital services, including representatives of State medical associations, State dental associations, State hospital associations, voluntary nonprofit prepaid medical and hospital care plans, and other groups interested in the improvement of medical, dental, and hospital services and in the better distribution thereof;

(4) contain satisfactory evidence that the State health agency, in cooperation with other public and private agencies, will have authority to carry out such plan in conformity with this part;

(5) set forth a State-wide program designed and calculated—

(A) to provide, within five years, medical and hospital services without discrimination to all those families and individuals in the State unable to pay the whole cost thereof;

(B) to provide dental services as far as practicable to such persons;

(C) to encourage the development of voluntary medical, dental, and hospital insurance plans operated not for profit;

(D) to provide for the establishment and staffing of general diagnostic facilities and the improvement of existing diagnostic facilities; and

(E) to provide inducements to physicians and dentists to practice in areas which, without such inducements, would be unable to attract needed physicians or dentists.

The services provided for under subparagraphs (A) and (B) may, at the option of the State, be furnished in one or more of the following ways: in institutions, in the home, or in physicians' or dentists' offices. Such program may also provide for the furnishing of such services by means of payments (in the nature of premiums or partial premiums or the reimbursement of expenses or otherwise) by the State to any voluntary medical, dental, or hospital insurance plan or other plan operated not for profit. Such program may include and take account of services rendered or to be rendered by governmental subdivisions of the State, and by private nonprofit organizations, and may provide for payments to such subdivisions or organizations for services furnished to families or individuals. Such program may provide for the collection of proper charges of less than the total cost of such services (whether provided by the State, governmental subdivision, private organization or nonprofit fund) from persons unable to pay in whole, but able to pay in part therefor.

The provisions of subparagraphs (B), (C), (D), and (E) hereof shall be optional with the State, and the methods by which they are to be carried out shall also be optional with the State if such methods are reasonably calculated to accomplish the purposes thereof: *Provided*, That not exceeding 25 per centum of the sums to be expended by the State in any one fiscal year pursuant to this part may be expended for the purposes set forth in subparagraphs (C), (D), and (E) of this paragraph;

(6) provide that the State shall set standards for the services to be provided under this part;

(7) provide that, in determining eligibility for services under this part, no excessive requirements shall be imposed with respect to duration and place of residence, and that citizenship shall not be a criterion of eligibility;

(8) provide safeguards which restrict the use of disclosure of information concerning individuals eligible for services under this part to purposes directly connected with the administration of such services;

(9) describe the financial contribution for the support of the plan to be made by the State, its local subdivisions, and its private institutions, which contributions shall, by the end of said period of five years, attain such a level as will, when taken together with the sums expected to be received from the Federal Government pursuant to this part, at least suffice to carry out the State plan. The financial contribution to be made by the State and its governmental subdivisions shall be at least equal to the amount expended by them for similar purposes in the fiscal year of the State ended in 1948, and at least equal to that part of the cost of the plan not covered by the Federal allotment (as provided in section 213) for such State;

(10) set forth the relative need for the various activities covered by the plan and provide for the proper priority between such activities, based upon such need, as financial resources and the necessary facilities and personnel become available;

(11) be based on a State-wide survey of existing medical, hospital, and dental services, including those provided by the State and its local subdivisions and by private individuals and organizations, and shall describe in detail the proposed extension of such services to the end that they be furnished in accordance with the provisions of this part;

(12) provide that the State agency will make such reports in such form and containing such information as the Director may from time to time reasonably require, and give the Director, upon demand, access to the records upon which the information is based; and

(13) provide that the State agency will from time to time review its State plan and the operation thereof and submit to the Director any modifications thereof which it considers necessary.

(b) The Director shall approve any plan and any modification thereof which fulfills the conditions specified in subsection (a). If any such plan or modification thereof shall have been disapproved by the Director for failure to comply with subsection (a), the National Medical and Dental Care Council created pursuant to section 215 (b) shall, upon request of the State agency, afford it an opportunity for hearing. If such Council determines that the plan or modification complies with the provisions of subsection (a), the Director shall thereupon approve such plan or modification. No plan or modification shall be disapproved because the Director disapproves of the methods proposed if the program is designed and calculated to achieve by July 1, 1954, the required objectives of this part, at a cost within the probable financial resources of the State with Federal aid.

ALLOTMENTS TO STATES FOR SERVICES

SEC. 213. (a) Each State for which a State plan has been approved prior to or during a fiscal year shall be entitled for such year to an allotment of a sum bearing the same ratio to the sum appropriated pursuant to section 211 for such year as the product of (1) the population of such State and (2) the square of its allotment percentage bears to the sum of the corresponding products for all the States. The allotment percentage for any State shall be 100 per centum less that percentage which bears the same ratio to 50 per centum as the per capita income of such State bears to the per capita income of the continental United States (excluding Alaska), except that (1) the allotment percentage shall in no case be more than 75 per centum or less than 33⅓ per centum, and (2) the allotment percentage for Hawaii shall be 50 per centum, and the allotment percentage for Alaska, Puerto Rico, and the Virgin Islands shall be 75 per centum each. The amount of the allotment to a State shall be available, in accordance with the provisions of this part, for payment of that per centum of the costs incurred in carrying out the approved plan within such State which does not exceed the allotment percentage for such State. The Director shall from time to time estimate the sum to which each State will be entitled under this section during such ensuing period as he may determine, and shall thereupon certify to the Secretary of the Treasury the amount so estimated, reduced or increased, as the case may be, by any sum by which the Director finds that his estimate for any prior period was greater or less than the amount to which the State was entitled for such period. The Secretary of the Treasury shall thereupon, prior to audit or settlement by the General Accounting Office, pay to the State, at the time or times fixed by the Director, the amount so certified.

(b) Sums allotted to a State for a fiscal year and remaining unobligated at the end of such year shall remain available to such State for such purpose for the next fiscal year (and for such year only), in addition to the sums allotted to such State for such next fiscal year. Any amount of the sum authorized to be appropriated for a fiscal year which is not appropriated for such year, or which is not allotted in such year by reason of the failure of any State or States to have plans approved under this title, or any amount allotted to a State, but remaining unobligated at the end of the period for which it is available to such State, is hereby authorized to be appropriated for the next fiscal year in addition to the sum otherwise authorized under section 211.

OPERATION OF STATE PLANS

SEC. 214. (a) If the Director, after reasonable notice and opportunity for hearing to the State agency, finds (1) that the State agency is not complying substantially with the provisions of the plan theretofore approved by the Director; or (2) that any Federal funds have been diverted from the purposes for which they have been allotted or paid under this title; or (3) that the State and its governmental subdivisions have failed to provide toward the carrying out of such plan at least as much as the sums required to be provided pursuant to section 212 (a) (9), the Director, with the approval of the Administrator, shall forthwith notify the Secretary of the Treasury and the State agency that no further certification will be made under section 213, and he shall withhold such further certifications until there is no longer any failure to comply. Until he is so satisfied he shall make no further certification to the Secretary of the Treasury with respect to such State.

(b) If any State is dissatisfied with the Director's action under subsection (a), such State may appeal to the United States court of appeals for the circuit in which such State is located. The summons and notice of appeal may be served at any place in the United States. The Director shall forthwith certify and file in the court the transcript of the proceedings and record on which he based his action.

(c) The findings of fact by the Director, unless substantially contrary to the weight of evidence, shall be conclusive; but the court, for good cause shown, may remand the case to the Director to take further evidence, and the Director may thereupon make new or modified findings of fact and may modify his previous action, and shall certify to the court the transcript and record of the further proceedings. Such new or modified findings of fact shall likewise be conclusive unless substantially contrary to the weight of the evidence.

(d) The court shall have jurisdiction to affirm the action of the Director or to set it aside, in whole or in part. The judgment of the court shall be subject to review by the Supreme Court of the United States upon certiorari or certification as provided in the United States Code, title 28, section 1254.

ADMINISTRATION

SEC. 215. (a) The Director is authorized to make such administrative regulations as he finds necessary to carry out the provisions of this title.

(b) In administering this title the Director shall consult with a National Medical and Dental Care Council (hereinafter called the "Council") consisting of the Director, ex officio, who shall serve as Chairman, and twelve members, not otherwise in the employ of the Federal Government, appointed by the Administrator. Eight of the twelve appointed members shall be persons who are outstanding in fields pertaining to medical, hospital, and dental care, at least three of whom shall be doctors of medicine, and at least one of whom shall be a doctor of dental surgery. The other four appointed members shall be persons familiar with the needs for medical, dental, and hospital care in urban or rural areas. Each appointed member shall hold office for a term of four years, except that any member appointed to fill a vacancy occurring prior to the expiration of the term for which his predecessor was appointed shall be appointed for the remainder of such term, and the terms of office of the members first taking office shall expire, as designated by the Administrator at the time of appointment, three at the end of the first year, three at the end of the second year, three at the end of the third year, and three at the end of the fourth year after the date of the appointment. An appointed member shall not be eligible to serve continuously for more than two terms but shall be eligible for reappointment if he has not served two consecutive terms immediately preceding his reappointment. The

Council is authorized to appoint such special and technical committees as may be useful in carrying out its functions. Appointed Council members and members of advisory or technical committees, while serving on the business of the Council, shall receive compensation at rates fixed by the Administrator, but not exceeding $50 per day, and shall also be entitled to receive an allowance for actual and necessary travel and subsistence expenses while serving away from their places of residence. The Council shall meet as frequently as the Director deems necessary, but not less than once each quarter. Upon request by four or more members, it shall be the duty of the Director to call a meeting of the Council.

(c) In administering the provisions of this title the Director is authorized to utilize the services and facilities of any executive department or agency in accordance with an agreement with the head thereof. Payment for such services and facilities shall be made in advance or by way of reimbursement, as may be agreed upon between the Director and the head of the department or agency furnishing them.

CONFERENCES WITH STATE AGENCIES

SEC. 216. Whenever in his opinion the purposes of this title would be promoted by a conference, the Director may invite representatives of as many State health agencies, designated in accordance with section 202 (a) (1) or section 212 (a) (1), to confer as he deems necessary or proper. Upon the application of five or more of such State agencies, it shall be the duty of the Director to call a conference of representatives of all State agencies joining in the request. A conference of the representatives of all such State agencies shall be called annually by the Director.

LIMITATIONS ON FEDERAL CONTROL

SEC. 217. Except as otherwise specifically provided, nothing in this title shall be construed as conferring on any Federal officer or employee the right to exercise any supervision or control over the administration, personnel, maintenance, or operation of the health services with respect to which any funds have been or may be expended under this title.

OBLIGATIONS TO VETERANS CONTINUED

SEC. 218. Nothing in this title shall modify obligations assumed by the Federal Government under other statutes for the medical and hospital care of veterans.

DEFINITION OF STATE

SEC. 219. As used in this title, the term "State" shall include the several States, the District of Columbia, Alaska, Hawaii, Puerto Rico, and the Virgin Islands.

TITLE III—HEALTH SERVICES FOR SCHOOL CHILDREN

APPROPRIATIONS AUTHORIZED

SEC. 301. (a) For the purpose of assisting the States to provide periodic health examinations and diagnosis, including dental examination, for all children of school age within the State in connection with their attendance at school, and to provide for the prevention and treatment of physical and mental defects and conditions, as hereinafter described, there is hereby authorized to be appropriated, without any limitation of such appropriation or condition inconsistent with or contrary to the terms or purposes of this title, for the fiscal year ending June 30, 1950, and for each fiscal year thereafter, the sum of $35,000,000 to be distributed among the States as hereinafter provided.

(b) There are hereby authorized to be appropriated such sums as may be necessary to pay the costs of administering this title.

ALLOTMENTS TO STATES

SEC. 302. (a) Each State shall be entitled for each fiscal year to an allotment of a sum bearing the same ratio to the sum appropriated pursuant to section 301 (a) for such year as the product of (1) the number of children in the State between the ages of five and seventeen, inclusive, and (2) the square of its allotment percentage (as defined in section 303 hereof) bears to the sum of the corresponding products for all of the States.

(b) The Director of the Office of Medical, Dental, and Hospital Services (hereinafter called the "Director") shall, with the approval of the Administrator, certify for each fiscal year the amount of the allotment to be paid under this title to each State that has qualified under section 304 of this title to the Secretary of the Treasury, who shall, through the fiscal service of the Treasury Department and prior to audit or settlement by the General Accounting Office, pay to the treasurer or corresponding official of such State the amount certified for such fiscal year in four installments. One such installment shall be paid as soon after the first day of each quarter as may be feasible, beginning with the first quarter of the first fiscal year for which appropriations made under the authorization of this title are available.

(c) If, in any State, the treasurer or corresponding official of such State is not permitted by law to disburse any of the funds authorized under section 301 (a) for the purpose of providing health services referred to in such section to children attending nonpublic schools, the Director shall withhold from the allotment of such State an amount which bears the same ratio to such allotment as the number of children in average daily attendance at nonpublic schools within such State bears to the total number of children in average daily attendance in all schools within such State. The Director shall, with the funds so withheld, make provision for such services to children attending the nonpublic schools within such State for the same purposes and subject to the same conditions as are authorized or required with respect to the disbursement of funds for such purposes for children attending public schools within the State.

ALLOTMENT PERCENTAGE

SEC. 303. For the purposes of this title—

(a) The allotment percentage for any State shall be 100 per centum less that percentage which bears the same ratio to 50 per centum as the per capita income of such State bears to the per capita income of the continental United States (excluding Alaska), except that (1) the allotment percentage shall in no case be more than 75 per centum or less than 33⅓ per centum and (2) the allotment percentage for Hawaii shall be 50 per centum and the allotment percentage for Alaska, Puerto Rico, the Virgin Islands, the Canal Zone, American Samoa, and Guam shall be 75 per centum.

(b) The allotment percentages shall be promulgated by the Director between July 1 and August 31 of each even-numbered year, on the basis of the average of the per capita incomes of the States and of the continental United States (excluding Alaska) for the three most recent consecutive years for which satisfactory data are available from the Department of Commerce. Such promulgation shall be conclusive for each of the two fiscal years in the period beginning July 1 next succeeding such promulgation: *Provided*, That the Director shall promulgate such percentages as soon as possible after the enactment of this Act, which promulgation shall be effective until June 30, 1951.

(c) The number of children between the ages of five and seventeen, inclusive, in the several States shall be determined on the basis of the latest figures certified by the Department of Commerce.

STATE ACCEPTANCE PROVISIONS

SEC. 304. (a) In order to qualify for receiving funds appropriated under this title a State shall accept the provisions of this title through its legislature, or through its chief executive until its legislature shall meet, and shall submit a plan through its chief executive to the Director for the administration of funds to be received, which plan shall be prepared by the State educational agency and State health agency jointly or, in Guam, American Samoa, or the Canal Zone, such agency as may be designated by the Governor. Such plan shall—

(1) set forth a school health program which (A) shall provide for medical and dental examinations at periodic intervals for all school children in the State, insofar as practicable at the schools which they attend, including nonpublic as well as public schools; (B) shall provide for treatment of such children for physical and mental defects and conditions shown by such examinations whenever the parents of such children are unable to provide such treatment; and (C) may provide for the prevention and treatment of such physical and mental defects and conditions for all school children. Such examinations and service shall be made available to children, on a just and

equitable basis, without regard to race, creed, color, or national origin, or the location or character of the school in which the examination is made. Such plan shall set forth the manner in which payments are to be made and examinations and treatment provided.

(2) provide the method by which the plan shall be administered and specify the State agency or agencies (which shall be the State health agency or the State educational agency, or both, except that in Guam, American Samoa, and the Canal Zone it shall be the agency or agencies designated by the Governor) which shall administer the plan and the division of powers and responsibilities between them, if there is more than one, in order to secure the most equitable provision of services provided by this title to all the school children of the State;

(3) provide that the State treasurer or corresponding official in the State shall receive the funds paid to the State under this title and shall be required to submit to the Director on or before the 1st day of November of each year, for transmission to the Congress, a detailed statement of the amount so received for the preceding fiscal year and of its disbursement;

(4) provide for an annual audit of the expenditure of funds received under this title, and for the submission of a copy thereof to the Director;

(5) provide for the expenditure of State and local funds in an amount not less than (A) the State percentage (as defined in sec. 307 (g)) of the total sum to be spent in the State, for the health services described in this title, or (B) the amount of such funds actually spent for such purposes in the fiscal year of the State ended in 1948, whichever is greater;

(6) provide that the State agency or agencies will make such reports, in such form and containing such information, as the Director may from time to time reasonably require, and give the Director, upon demand, access to the records upon which the information is based.

(7) provide for the designation of a State advisory council which shall include representatives of nongovernmental organizations or groups, and of State agencies, concerned with health, education, child welfare, and the interests of the public at large, to consult with the State agency or agencies administering the plan with respect to the operation of such plan;

(8) provide that the school health services developed in accordance with this title shall utilize and develop the qualified health, medical, dental, hospital, and other related facilities already established in the State;

(9) provide for cooperation with medical, dental, health, nursing, psychiatric, educational, and welfare groups and organizations, and, where necessary, for working agreements with State or local public agencies having authority under State law for the care of crippled or otherwise physically handicapped children, or for other necessary health services; and

(10) provide that the State shall set standards for the services to be provided under this title.

(b) The Director shall approve any State plan which complies with the provisions of subsection (a).

OPERATION OF STATE PLANS

SEC. 305. In the case of any State plan for school health services which has been approved by the Director, if the Director, after reasonable notice and opportunity for hearing to the State agency or agencies administering such plan, finds that in the administration of the plan there is a failure to comply substantially with any provision required by section 304 to be included in the plan, or finds, after October 1, 1952, that such plan is not yet in full effect, he shall notify the Secretary of the Treasury and such State agency or agencies that further payments will not be made to the State until he is satisfied that there is no longer any failure to comply. Until he is so satisfied he shall make no further certification to the Secretary of the Treasury with respect to such State.

RIGHT OF APPEAL

SEC. 306. (a) If any State is dissatisfied with the Director's action under section 304 (b) or section 305 hereof, such State may appeal to the United States court of appeals for the circuit in which such State is located. The summons and notice of appeal may be served at any place in the United States. The Director shall forthwith certify and file in the court the transcript of the proceedings and the record on which he based his action.

(b) The findings of fact by the Director, unless substantially contrary to the weight of the evidence, shall be conclusive; but the court, for good cause shown, may remand the case to the Director to take further evidence, and the Director may thereupon make new or modified findings of fact and may modify his previous action, and shall certify to the court the transcript and record of the further proceedings. Such new or modified findings of fact shall likewise be conclusive unless substantially contrary to the weight of the evidence.

(c) The court shall have jurisdiction to affirm the action of the Director or to set it aside, in whole or in part. The judgment of the court shall be subject to review by the Supreme Court of the United States upon certiorari or certification as provided in the United States Code, title 28, section 1254.

DEFINITIONS

Sec. 307. As used in this title—

(a) The term "State" shall include the several States, the District of Columbia, Alaska, Hawaii, Puerto Rico, the Canal Zone, American Samoa, the Virgin Islands, and Guam.

(b) The term "legislature" means the State or Territorial legislature or other comparable body, except that in the District of Columbia it shall mean the Board of Education, and in American Samoa, the Canal Zone, and the Virgin Islands it shall mean the Governor.

(c) The term "schools" means only elementary and secondary schools, and the term "nonpublic schools" means those schools exempt under section 101 (6) of the Internal Revenue Code, as amended, which, while performing the public function of educating children in accordance with the State educational requirements, are not administered by public authorities.

(d) The term "school children" means all children between the ages of five and seventeen, inclusive, attending schools.

(e) A just and equitable basis for the provision for health services provided under this title for the benefit of children attending public schools maintained for minority races in a State which maintains by law separate public schools for minority races means a basis which provides for children attending such schools the same health services as are provided for children in other public schools in the State.

(f) The term "minority race" means any race or racial group that constitutes a minority of the population of the continental United States.

(g) The State percentage shall be that percentage which bears the same ratio to 50 per centum as the per capita income of such State bears to the per capita income of the continental United States, except that (1) the State percentage shall in no case be more than 50 per centum or less than 25 per centum, and (2) the State percentage for Hawaii shall be 50 per centum, and the State percentage for Alaska, Puerto Rico, the Virgin Islands, the Canal Zone, American Samoa, and Guam shall be 25 per centum.

The State percentages shall be promulgated by the Director between July 1 and August 31 of each even-numbered year, on the basis of the average of the per capita incomes of the States and of the continental United States (excluding Alaska) for the three most recent consecutive years for which satisfactory data are available from the Department of Commerce. Such promulgation shall be conclusive for each of the two fiscal years in the period beginning July 1 next succeeding such promulgations: *Provided*, That the Director shall promulgate such percentages as soon as possible after the enactment of this title, which promulgation shall be effective until June 30, 1951.

TITLE IV—AMENDMENTS TO HOSPITAL SURVEY AND CONSTRUCTION ACT

EXTENSION OF DURATION AND INCREASE IN AUTHORIZED APPROPRIATIONS FOR HOSPITAL CONSTRUCTION

Sec. 401. In order to provide greater financial assistance to the States for the construction of hosptials—

(a) The first sentence of section 621 of the Public Health Service Act is amended to read as follows: "In order to assist the States in carrying out the purposes of section 601 (b), there is hereby authorized to be appropriated for the fiscal year ending June 30, 1950, and for each of the five succeeding fiscal years, the sum of $150,000,000 for the construction of public and other nonprofit hospitals; and there are further authorized to be appropriated for such construction the sums provided in section 624."

(b) The paragraph "Grants for hospital construction" under the heading "Public Health Service" in the Federal Security Agency Appropriation Act, 1949, is amended by striking out "$75,000,000" and inserting in lieu thereof "$150,000,000".

ADDITIONAL FEDERAL AID IN CONSTRUCTION OF HOSPITALS

SEC. 402. (a) Sections 624, 625 (a), and 625 (b) of such Act are each amended by striking out "33⅓ per centum" and inserting in lieu thereof "the State's allotment percentage".

(b) Section 625 (e) of such Act is amended by striking out "33⅓ per centum of the then value of such hospital, as determined by agreement of the parties or by action brought in the district court of the United States for the district in which such hospital is situated" and inserting in lieu thereof the following: "an amount bearing the same ratio to the then value (as determined by agreement of the parties or by action brought in the district court of the United States for the district in which such hospital is situated) of the hospital, or of that portion of the hospital which constituted an approved project, as the amount of the Federal participation bore to the cost of the construction of such project".

REQUIREMENT OF ADEQUATE STATE ADMINISTRATION

SEC. 403. Section 632 (a) of such Act is amended by inserting after "under section 625" in clause (4) thereof a comma and the following: "or (5) that adequate State funds are not being provided annually for the direct administration of the State plan (which shall be not less than $15,000 or 1 per centum of the total funds proposed to be expended during the year under the plan, whichever is the higher)".

STUDIES AND DEMONSTRATIONS RELATING TO COORDINATED USE OF HOSPITAL FACILITIES

SEC. 404. Such Act is further amended by adding after section 635 the following new section:

"STUDIES AND DEMONSTRATIONS RELATING TO COORDINATED USE OF HOSPITAL FACILITIES

"SEC. 636. In carrying out the purposes of section 301 with respect to hospital facilities, the Surgeon General is authorized to conduct research, experiments, and demonstrations relating to the effective development and utilization of hospital services, facilities, and resources, and, after consultation with the Federal Hospital Council, to make grants-in-aid to States, political subdivisions, universities, hospitals, and other public and private nonprofit institutions or organizations for projects for the conduct of research, experiments, or demonstrations relating to the development, utilization, and coordination of hospital services, facilities, and resources. Any award made under this section for any such project in any fiscal year may include amounts for not to exceed the four succeeding fiscal years, and such amounts for such succeeding fiscal years shall constitute contractual obligations of the Federal Government: *Provided*, That the total of such obligations for all such projects to be paid in any such succeeding fiscal year may not exceed $1,200,000."

PURPOSE OF ACT

SEC. 405. Section 601 of such Act is amended to read as follows:

"SEC. 601. The purpose of this title is—

"(a) to assist the several States to inventory their existing hospitals (as defined in section 631 (e)), to survey the need for construction of hospitals, and to develop programs for construction of such public and other nonprofit hospitals as will, in conjunction with existing facilities, afford the necessary physical facilities for furnishing adequate hospital, clinic, and similar services to all their people;

"(b) to assist in the construction of public and other nonprofit hospitals in accordance with such programs; and "(c) to authorize the Surgeon General to conduct, and make grants for the conduct of, research, experiments, and demonstrations relating to the effective development and utilization of hospital services, facilities, and resources, and to promote the coordination of such experiments and demonstrations and the useful application of their results."

EFFECTIVE DATE

SEC. 406. This title shall take effect upon the date of its enactment except that (1) the amendments made by section 402 (a) shall be effective with respect to projects approved under section 625 of the Public Health Service Act on and after January 1, 1949, and (2) section 404 shall take effect July 1, 1949.

TITLE V—LOCAL PUBLIC HEALTH UNITS

AMENDMENTS TO PUBLIC HEALTH SERVICE ACT

SEC. 501. In order to assist the States in the development and maintenance of local public health units—

(a) section 315 of the Public Health Service Act, as amended, is amended by redesignating such section as section 304; and

(b) part B of title III of such Act is amended by adding at the end thereof the following new section:

"GRANTS TO STATES FOR LOCAL PUBLIC HEALTH UNITS

"SEC 315. (a) For the purposes of this section—

"(1) the term 'local public health unit' means the governmental authority of a local area authorized to provide in such area the basic public health services for which funds are made available under this section (including a unit of a State government specifically assigned responsibility for the provision of basic public health services in a local area), or a combination of the governmental authorities of two or more contiguous local areas authorized to provide such services in such combined area;

"(2) the term 'population' (A), as applied to a State, means the population thereof according to the latest estimates available from the Department of Commerce on August 31 of the year preceding the fiscal year (or portion thereof) for which a determination with respect to such population is made under this section, and (B), as applied to less than State-wide areas, means the population of such areas according to the most recent decennial census figures certified by the Department of Commerce that are available on August 31 of the year preceding the fiscal year (or portion thereof) for which a determination with respect to such population is made under this section, increased or decreased in proportion to the increase or decrease since such census of the population of the State as estimated in accordance with clause (A) hereof;

"(3) the average per capita income of the United States or the average per capita income of a State, as the case may be, means its average per capita income for the three most recent consecutive years for which satisfactory data are available from the Department of Commerce on August 31 of the year preceding the fiscal year for which the determination is made, except that the average per capita income of Hawaii shall be deemed to be equal to that of the continental United States (excluding Alaska) and the average per capita income of Alaska, Puerto Rico, and the Virgin Islands shall be deemed to be equal to one-half of that of the continental United States (excluding Alaska).

"(b) To enable the Surgeon General to assist the States and their subdivisions in establishing and maintaining adequately staffed and equipped local public health units for the provision of basic public health services, there are hereby authorized to be appropriated such sums as may be necessary to carry out the purposes of this section. The sums appropriated pursuant to this section shall be used for making payments to States which have submitted, and had approved by the Surgeon General, State plans for carrying out the purposes of this section.

"(c) Within six months after the enactment of this section, the Surgeon General shall by regulation prescribe—

"(1) criteria for determining the minimum population and financial resources which various types of areas must have, and the minimum number and types of full-time professional and other personnel which local public health units in various types of areas must employ per thousand population, in order to afford reasonable assurance of continued financial support for, and efficient and economic administration of, basic public health services in such areas;

"(2) criteria for determining whether methods for allocating, under State plans, the funds made available under this section to local public health units are equitable and such as to assure the effective use of such funds in the provision of basic public health services;

"(3) subject to the limits set forth in subsection (d) (5), general methods of administration necessary to assure efficient and economical provision of basic public health services under State plans, including the conditions under which compliance with such methods may be postponed;

"(4) types of health services, including the training of personnel for local public health work, which shall be considered basic public health services for which funds may be expended under State plans, consideration being given in such regulations to the types of health services for which Federal aid is available under other provisions of law.

"(d) In order to be approved under this section, a State plan shall—

"(1) set forth a program for the extension of the State plan so as to assure coverage under the plan of all areas in the State;

"(2) contain satisfactory evidence that the State health authority and the local publis health units of the State whose populations are covered by the State plan will have authority to carry out the plan in conformity with the provisions of this section and regulations prescribed thereunder;

"(3) provide that each local public health unit providing basic public health services under the plan service an area of sufficient population and financial resources to assure continued financial support for, and efficient and economical administration of, such basic health services; and employ full-time personnel of such types and in such numbers as are required to render minimum basic public health services to the population served by the local public health unit;

"(4) provide for the allocation of all funds received by the State health authority under this section to local public health units participating in the State plan in accordance with methods that will assure equitable distribution and the effective use of such funds in the extension and expansion of basic public health services, and provide that all such funds shall be used by such units solely for the provision of such services;

"(5) provide such methods of administration of the State plan, including methods relating to the establishment and maintenance of personnel standards on a merit basis (except that the Surgeon General shall exercise no authority with respect to the selection, tenure of office, or compensation of any individual employed in accordance with such methods), as may be necessary to assure the efficient and economical provision of basic public health services under the plan;

"(6) provide that the State health authority will make such reports, in such form and containing such information, as the Surgeon General may from time to time reasonably require, and give the Surgeon General upon demand access to the records upon which such information is based.

The Surgeon General shall approve any State plan and any modification thereof which complies with the provisions of this subsection and regulations prescribed under subsection (c).

"(e) From the sums appropriated pursuant to this section, each State which has a State plan approved in accordance with subsection (d) shall be entitled to receive for each fiscal year an amount which bears the same ratio to one-third of the expenditures for such year under the plan as the average per capita income of the continental United States (excluding Alaska) bears to the average per capita income of such State, except that (1) in no case may the amount paid to such State for a fiscal year exceed two-thirds of the expenditures under the State plan for such year, and (2) there shall not be counted as expenditures under the State plan for any fiscal year any sum in excess of $1.50 (or such higher amount as may be specified in the appropriation pursuant to this section for such year) multiplied by the population of the local public health units participating in the State plan. If, during the fiscal year, the areas covered by the State plan are changed, appropriate adjustments, prorated in accordance with the time the change becomes effective, shall be made in determining the maximum amount of the expenditures.

"(f) The Surgeon General shall, prior to the beginning of each period for which a payment is to be made, estimate the amount to be paid to the State for such period pursuant to subsection (e), and shall then certify to the Secretary of the Treasury the amount so estimated, increased or decreased, as the case may be, by any sum by which he finds that his estimate for any prior period was greater or less than the amount which should have been paid to the State under subsection (e) for such period. The Secretary of the Treasury shall thereupon, prior to audit or settlement by the General Accounting Office, pay to the State, at the time or times fixed by the Surgeon General, the amount so certified.

"(g) Whenever the Surgeon General, after reasonable notice and opportunity for hearing to the health authority of the State finds—

"(1) that the State plan has been changed so that it no longer complies with the requirements of subsection (d) ; or

"(2) that in the administration of the plan there is a failure to comply substantially with any provision required by subsection (d) to be included in the plan; the Surgeon General shall notify such State health authority that further payments will not be made to the State from appropriations pursuant to this section (or, in his discretion, that further payments will not be made to the State from such appropriations for activities or areas in which there is such failure) until he finds that the plan again complies with such requirements or until he is satisfied that there will no longer be any such failure. Until he so finds, or is so satisfied, the Surgeon General shall make no further certification for payment to such State from appropriations pursuant to this section, or shall limit payment to activities or areas in which there is no such failure."

GRANTS TO STATES UNDER SECTION 314 OF THE PUBLIC HEALTH SERVICE ACT

SEC. 502. (a) Subsection (c) of section 314 of the Public Health Service Act, as amended, is amended to read as follows:

"(c) To enable the Surgeon General to assist, through grants and as otherwise provided in this section, States, counties, health districts, and other political subdivisions of States in establishing and maintaining adequate public health services, including grants for demonstrations, for the training of personnel for State and local health work, and for the cost to the State health authority of administering the State plan approved under section 315, but excluding grants for basic public health services for which appropriations are authorized under such section, and to enable the Surgeon General to provide demonstrations and to train personnel for State and local health work (directly or through grants to public and other nonprofit institutions offering training in public health work) and to meet the cost of pay, allowances, and traveling expenses of commissioned officers and other personnel of the Service detailed to assist States in carrying out the purposes of this subsection, there is hereby authorized to be appropriated such sums as are necessary to carry out the purposes of this subsection."

(b) The first sentence of subsection (d) of such section 314 is amended to read as follows:

"(d) For each fiscal year, the Surgeon General, with the approval of the Administrator, shall determine the total sum from the appropriation under subsection (a), the appropriation under subsection (b), and the appropriation under subsection (c) which shall be available for allotment among the several States."

(c) Subsection (i) of such section 314 is amended to read as follows:

"(i) All regulations and amendments thereto with respect to grants to States under this section or section 315 shall be made after consultation with a conference of State health authorities and, in the case of regulations or amendments which relate to or in any way affect grants under subsection (c) of this section for work in the field of mental health, the State mental health authorities. Insofar as practicable, the Surgeon General shall obtain the agreement, prior to the issuance of any such regulations or amendments, of the State health authorities and, in the case of regulations or amendments which relate to or in any way affect grants under subsection (c) of this section for work in the field of mental health, the State mental health authorities."

TITLE VI—STUDIES AND GRANTS FOR INCREASING AVAILABLE MANPOWER IN THE HEALTH PROFESSIONS

PART A—STUDY OF TRAINING FACILITIES AND MANPOWER REQUIREMENTS

COMMISSION ON MANPOWER IN THE HEALTH PROFESSIONS

SEC. 601. (a) There is hereby established a Commission on Manpower in the Health Professions, hereinafter called the "Commission."

(b) The Commission shall consist of sixteen Commissioners, including the Surgeon General of the Public Health Service, the Commissioner of Education, the Chief Medical Director of the Department of Medicine and Surgery of the Veterans' Administration, and a representative of the medical services of the National Military Establishment (to be designated by the Secretary of National Defense), who shall serve ex officio, and twelve Commissioners to be appointed by the President on or before October 1, 1949, who shall be persons not otherwise in the employ of the Federal Government. At least eight of the twelve appointed Commissioners shall be persons outstanding in the fields of medicine, dentistry, nursing, public health, or higher education who are familiar with the problems of manpower in the health professions.

(c) The Commission shall elect a Chairman and a Vice Chairman from among its membership. Nine Commissioners shall constitute a quorum. Any vacancy in the Commission shall not affect its powers, but shall be filled in the same manner in which the original appointment was made.

(d) The Commission shall continue in existence until ninety days after completion of the submission of its report as provided in section 602. Each of the twelve appointed Commissioners, while attending meetings of the Commission or while otherwise serving pursuant to this part, shall be entitled to receive $50 per diem, and shall also be entitled to receive an allowance for actual and necessary traveling and subsistence expenses while so serving away from his place of residence.

STUDY OF NEEDS FOR HEALTH PERSONNEL

SEC. 602. It shall be the duty of the Commission to make a thorough study of the present and long-range needs for medical, dental, nursing, public-health, and other professional health personnel in the United States, and of the numbers and manner (including facilities) in which such personnel are and ought to be trained, distributed, and utilized, in order best to meet the health needs of the Nation; and to submit to Congress one or more reports containing its findings and recommendations based on such study. Such report or reports shall be submitted on or before January 15, 1952.

POWERS OF COMMISSION

SEC. 603. (a) The Commission shall have power to appoint and fix the compensation of such personnel as it deems necessary, in accordance with the provisions of the civil-service laws and the Classification Act of 1923, as amended.

(b) The Commission may, in its discretion, enter into contracts with private individuals, nonprofit educational or research organizations, organizations of the health professions, or non-Federal public agencies, for the performance of research which it deems necessary.

(c) The Commission, or any member thereof, may, for the purpose of carrying out the provisions of this part, hold such hearings and sit and act at such times and places, and take such testimony, as the Commission or such member may deem advisable. Any member of the Commission may administer oaths or affirmations to witnesses appearing before the Commission or before such member.

(d) The Commission is authorized to secure directly from any executive department, bureau, agency, board, commission, office, independent establishment, or instrumentality information, suggestions, estimates, and statistics for the purpose of this part; and each such department, bureau, agency, board, commission, office, establishment, or instrumentality is authorized and directed to furnish such information, suggestions, estimates, and statistics directly to the Commission, upon request made by the Chairman or Vice Chairman.

AUTHORIZATION OF APPROPRIATIONS

SEC. 604. There are hereby authorized to be appropriated, out of any money in the Treasury not otherwise appropriated, such sums as may be necessary to carry out the provisions of this part.

PART B—TEMPORARY PAYMENTS TO MEDICAL SCHOOLS FOR MAINTAINING AND INCREASING ENROLLMENT

APPROPRIATIONS AUTHORIZED FOR ASSISTANCE TO MEDICAL SCHOOLS

SEC. 611. In order to enable the National Health Administrator, through payments to schools, to assist temporarily in maintaining and increasing the number of individuals trained annually in the field of medicine, there are hereby authorized to be appropriated for the fiscal years ending June 30, 1950, June 30, 1951, and June 30, 1952, such sums as may be necessary. Payments to any school from appropriations under this section may be used by such school to meet the costs (herein referred to as "costs of instruction") of maintaining and enlarging its staff, and of maintaining and operating its facilities (including the acquisition of equipment).

PAYMENTS TO SCHOOLS

SEC. 612. Payments under section 611 for each of the fiscal years ending June 30, 1950, June 30, 1951, and June 30, 1952, shall be made by the Administrator to any school of medicine which has submitted, and had approved by him, an application in accordance with section 613 (a), for such payments in such year. The sum of $500 shall be paid for each student enrolled in the school in such year, up to the average past enrollment of the school, and the sum of $750 shall be paid for each student in excess of the average past enrollment. The average past enrollment of a school shall be the average of its student enrollments during the three academic years next preceding the academic year for which the calculation is made.

APPLICATION BY SCHOOLS FOR PAYMENTS

SEC. 613. (a) Any school desiring payments under section 611 may file an application with the National Health Administrator for the fiscal year in which such payments are desired. Such application shall contain such information, necessary for determining the eligibility of such school for such payments, as the Administrator may by regulation prescribe, and shall also contain adequate assurance that—

(1) such school does not and will not impose any unreasonable restrictions against the admission of out-of-State students; and

(2) such school will submit from time to time such reports as the Administrator may find necessary to carry out the purposes of this part, and will comply with such other conditions as may, subject to the provisions of section 616, be prescribed in regulations.

(b) No payment shall be made under section 611 to any school unless the Administrator finds that such school will admit students without discrimination on account of race, creed, color, or national origin, except that, in the case of schools located within a State in which separate facilities are required by law to be maintained for minority races, such payments may be made to schools which admit members of such races, and may be made to any school which will not admit members of such races if the Administrator finds that there are comparable opportunities for qualified members of such races who reside in the State to obtain the type of professional training offered by such school. As used in this section, the term "minority race" means any race or racial group that constitutes a minority of the population of the continental United States.

CERTIFICATION OF PAYMENTS

SEC. 614. (a) The Administrator, in accordance with regulations, shall determine from time to time the amount to be paid to each school under this part and shall certify to the Secretary of the Treasury the amounts so determined. Upon receipt of any such certification, the Secretary of the Treasury shall, prior to audit or settlement by the General Accounting Office, pay in accordance with such certification.

(b) Whenever the Administrator, after reasonable notice and opportunity for hearing to a school, finds with respect to payments to such school from appropriations under section 611 that there is a failure to carry out any of the requirements of, or assurances given pursuant to, section 613, or to comply with regulations issued in conformity with this part, the Administrator shall notify such school that further payments will not be made to it from appropriations under section 611 until he is satisfied that there is no longer any such failure. Until he is so satisfied the Administrator shall make no further certification for payments to such school from appropriations under such section.

REGULATIONS

Sec. 615. The Administrator is authorized to issue such regulations as he may deem necessary for carrying out the provisions of this part. When such regulations concern payments to schools or the conditions with which schools must comply, as set forth in sections 612, 613, and 614, in order to become or remain eligible for such payments, he shall issue such regulations only after consulting with, and, insofar as possible, obtaining the concurrence of, the schools which may be affected thereby or the representatives designated by such schools for such consultation.

LIMITATION ON FEDERAL CONTROL

Sec. 616. Except as otherwise expressly provided in this part, nothing in this part shall be construed as authorizing any department, agency, officer, or employee of the United States to exercise any control over, or prescribe any requirements with respect to, the curriculum, teaching personnel, or administration of any school, or the admission of applicants thereto.

AUDIT

Sec. 617. The Administrator shall provide for an annual audit of expenditures made under this part and shall include in his annual report for transmission to Congress a full report of the administration of this part, including the essential facts about the program carried on under this part, a detailed statement of appropriations and disbursements, a summary and analysis of legislative and administrative provisions adopted for the expenditure of funds received under this part, and statistical information showing the results achieved through the expenditure of such funds.

DEFINITIONS

Sec. 618. As used in this part—

(a) the term "student" means a person enrolled in and actually attending the school of medicine who devotes essentially full time to pursuing a course of training leading to the degree of doctor of medicine; and

(b) the term "school of medicine" means a public or nonprofit institution within the continental United States offering a course of instruction in medicine leading toward the degree of doctor of medicine, which is exempt from Federal taxation and has been approved or accredited by a body designated for such purpose by the Administrator.

TITLE VII—MISCELLANEOUS

Sec. 701. Section 2 (c) of the Public Health Service Act is amended to read as follows:

"(c) The term 'Administrator' means the National Health Administrator."

Sec. 702. Sections 201 (c) and (d) of the Federal Food, Drug, and Cosmetic Act, as amended (U. S. C., title 21, sec. 321), are hereby amended to read as follows:

"(c) The term 'Agency' means the National Health Agency.

"(d) The term 'Administrator' means the National Health Administrator."

Sec. 703. Upon the direction of any officer or employee of the Government of the United States, requesting the Government to deduct from the salary of such officer or employee a fixed sum or percentage to be paid to any voluntary nonprofit health insurance fund, said sum or percentage shall be deducted from the salary of such officer or employee and shall be paid as directed by him. The term "United States" in this section shall be deemed to include all departments, bureaus, agencies, and other divisions of the Government and also corporations, the stock of which is wholly owned by the said Government. The term "health insurance fund" shall be deemed to include any nonprofit organization undertaking to provide, or to insure against the expense of, hospital, medical, dental, or any other services connected with health.

SEC. 704. The Secretary of the Treasury is authorized and directed, beginning with the fiscal year ending June 30, 1950, to deposit for each year in a special fund in the Treasury of the United States proceeds of taxes, duties, imposts, or excises in an amount equal to the aggregate of the amounts authorized to be appropriated for such year under this Act. Amounts deposited in such fund shall be available for expenditure only pursuant to appropriations made under authority of this Act, and no money shall be payable on any of said appropriations except from said fund. Any amounts remaining in the fund after the expiration of the period for which such amounts are available for expenditure shall be covered into the general fund of the Treasury.

SEC. 705. If any provision of this Act, or the application thereof to any person or circumstance, is held invalid, the remainder of the Act and the application of such provision to other persons or circumstances shall not be effected thereby.

[S. 1679, 81st Cong., 1st sess.]

A BILL To provide a program of national health insurance and public health and to assist in increasing the number of adequately trained professional and other health personnel, and for other purposes

Be it enacted by the Senate and House of Representatives of the United States of America in Congress assembled, That this Act, with the following table of contents, may be cited as the "National Health Insurance and Public Health Act."

TABLE OF CONTENTS

Page
5 Sec. 2. Declaration of purpose.

TITLE I—EDUCATION OF HEALTH PERSONNEL

PART A—EDUCATION IN THE MEDICAL, DENTAL, DENTAL HYGIENE, PUBLIC HEALTH, NURSING, SANITARY ENGINEERING, HOSPITAL ADMINISTRATION, AND RELATED PROFESSIONS

12 Sec. 372. Payments to schools for costs of instruction.
17 Sec. 373. Appropriations for grants for construction and equipment.
19 Sec. 374. Conditions for grants.
21 Seu. 375. Payments and withholding or recapture of payments.
22 Sec. 376. Appropriations authorized for scholarships.
23 Sec. 377. Apportionments to States for scholarships.
25 Sec. 378. State plans for scholarships.
26 Sec. 379. Conditions for award of scholarships.
29 Sec. 380. Payments to States for scholarships.
30 Sec. 381. Regulations.
30 Sec. 382. General provisions.
31 Sec. 102. National Council on Education for Health Professions.

PART B—PRACTICAL NURSE TRAINING

33 Sec. 111. Definitions.
33 Sec. 112. State plans.
36 Sec. 113. Authorizations for appropriations.
37 Sec. 114. Requirements as to matching of funds.
38 Sec. 115. Payments to States.
39 Sec. 116. Regulations.
39 Sec. 117. Administration.
39 Sec. 118. Annual report.
40 Sec. 119. Advisory committees.
40 Sec. 120. Withholding or recapture of payments.

TITLE II—MEDICAL RESEARCH

41 Sec. 201. Purpose.
42 Sec. 431. Establishment of institutes.
43 Sec. 432. Establishment of national advisory councils.
44 Sec. 413. Functions.
46 Sec. 406. Other authority.

TITLE III—HOSPITAL SURVEY AND CONSTRUCTION AMENDMENTS

47 Sec. 301. Purpose
48 Sec. 601. Amendment of purpose of survey provisions.
49 Sec. 614. Grants for administrative expenses of State agencies.
52 Sec. 304. Appropriations.
52 Sec. 305. Group practice facilities.
52 Sec. 306. State standards for variable grants.
53 Sec. 624. Allotments to States.
54 Sec. 625. Approval of projects and payments for construction.
59 Sec. 309. Definitions.
62 Sec. 310. Withholding of certification.
63 Sec. 636. Studies and demonstrations relating to coordinated use of hospital facilities.
64 Sec. 312. Effective dates.

TITLE IV—SPECIAL AID FOR RURAL AND OTHER SHORTAGE AREAS

PART A—RELIEF OF SHORTAGES IN RURAL AND OTHER AREAS

65 Sec. 401. Purpose.
66 Sec. 402. Measures authorized.
69 Sec. 403. Relationship to hospital construction provisions.
70 Sec. 404. Administration of grants for professional education.
71 Sec. 405. Appropriations authorized.
71 Sec. 406. Payments.
71 Sec. 407. Administration.

PART B—ASSISTANCE TO FARMERS' EXPERIMENTAL HEALTH COOPERATIVES

72 Sec. 421. Purpose and authorization of appropriations.
73 Sec. 422. Cooperatives eligible.
74 Sec. 423. Conditions for grants.
75 Sec. 424. Payments of grants.
76 Sec. 425. Administration.
76 Sec. 426. Withholding.
77 Sec. 427. Definitions.

TITLE V—GRANTS TO STATES FOR STATE AND LOCAL HEALTH WORK

77 Sec. 501. Purpose.
79 Sec. 314. Appropriations for grants and services to States.
80 Sec. 315. Allotment to States.
80 Sec. 316. Approval of State plans.
83 Sec. 317. Payments to States.
85 Sec. 318. Operation of State plans.
86 Sec. 319. Regulations.
86 Sec. 503. Use of existing appropriations.
86 Sec. 504. Vital statistics.
87 Sec. 313. Public education, information, and vital statistics.

TITLE VI—RESEARCH IN CHILD LIFE AND GRANTS FOR MATERNAL AND CHILD HEALTH AND CRIPPLED CHILDREN'S SERVICES

PART A—RESEARCH IN CHILD LIFE

87 Sec. 601. Authorization of appropriation.
89 Sec. 602. Contractual authority.
90 Sec. 603. National Advisory Council on Research in Child Life.
91 Sec. 604. Coordination of activities.
91 Sec. 605. Existing authorities preserved.

PART B—GRANTS TO STATES

91 Sec. 611. Purposes.
93 Sec. 612. Authorization of appropriations.
94 Sec. 613. Allotments to States.
95 Sec. 614. Approval of State plans.
97 Sec. 615. Payments to States.
100 Sec. 616. Operation of State plans.
101 Sec. 617. Administration.
101 Sec. 621. Regulations.
101 Sec. 622. Advisory committees.
102 Sec. 623. Annual report.
102 Sec. 624. Definition of State.
102 Sec. 625. Existing laws and appropriations.

TITLE VII—PREPAID PERSONAL HEALTH INSURANCE BENEFITS

PART A—FINDINGS AND DECLARATIONS

PART B—BENEFITS AND ELIGIBILITY

104 Sec. 701. Classes of personal health services.
106 Sec. 702. Availability of benefits.
107 Sec. 703. How benefits obtained; Free choice by patient.
109 Sec. 704. Eligibility for benefits.
111 Sec. 705. Provisions of benefits for noninsured needy and other individuals.

PART C—PARTICIPATION OF PHYSICIANS, DENTISTS, NURSES, HOSPITALS, AND OTHERS

112 Sec. 711. Physicians and dentists; Specialists.
113 Sec. 712. Nurses.
113 Sec. 713. Hospitals.
114 Sec. 714. Auxiliary services.
114 Sec. 715. Agreements with individual practitioners, hospitals, and others.
115 Sec. 716. Agreements with voluntary health insuranue and other organizations.
116 Sec. 717. Provisions common to all agreements.
118 Sec. 718. Methods of payments for services.
120 Sec. 719. Amount of payments for services.
122 Sec. 720. Professional rights and responsibilities.

PART D—LOCAL ADMINISTRATION

123 Sec. 731. Decentralization of administration.
124 Sec. 732. Local administrative committee or officer.

125 Sec. 733. Local area committees.
127 Sec. 734. Local professional committees.
128 Sec. 735. Methods of administration.

PART E—STATE ADMINISTRATION

130 Sec. 741. Declaration of policy.
130 Sec. 742. State plan of operations.

PART F—NATIONAL HEALTH INSURANCE BOARD; NATIONAL ADVISORY MEDICAL POLICY COUNCIL; GENERAL ADMINISTRATIVE PROVISIONS

136 Sec. 751. National Health Insurance Board.
140 Sec. 752. Advisory Council.
142 Sec. 753. Studies, recommendations, and reports.
142 Sec. 754. Nondisclosure of information.
143 Sec. 755. Prohibition against discrimination.

PART G—ELIGIBILITY DETERMINATIONS, COMPLAINTS, HEARINGS, AND JUDICIAL REVIEW

143 Sec. 761. Determinations as to eligibility for benefits.
144 Sec. 762. Complaints of eligible individuals and of persons furnishing benefits.

PART H—FISCAL PROVISIONS

147 Sec. 771. Personal health-service account.
149 Sec. 772. Allotment of funds.
153 Sec. 773. Grants-in-aid for training and education.

PART I—MISCELLANEOUS PROVISIONS

155 Sec. 781. Definitions.
161 Sec. 782. Availability of public-assistance grants for securing personal health-service benefits.
163 Sec. 783. Effective date.

DECLARATION OF PURPOSE

SEC. 2. Because the health of its people is the foundation of our Nation's strength, productivity, and wealth;

Because the assurance of adequate medical care to all of our people is essential to the general welfare and to the Nation's security;

Because the tremendous advances in medical science in recent years have necessarily meant great increases in the cost of health services, our archaic system of paying for medical care—based on public and private charity for the poor, on unpredictable and often unbearable costs to the otherwise self-supporting, and on disproportionate charges for the well-to-do—has resulted in the following conditions:

1. The inability of the vast majority of our people to meet the shattering cost of serious or chronic illness;
2. The inability of most of our people to benefit from modern preventative medicine;
3. A critical shortage of physicians, dentists, hospital administrators, dental hygienists, nurses, sanitary engineers, and other health personnel;
4. A critical shortage of hospitals, diagnostic and other clinics, rapid-treatment centers, group-practice facilities, and other categories of medical facilities;
5. Wholly inadequate provision for the health needs of our farm families and agricultural workers;
6. The development of research on a scale appallingly inadequate in relation to the dreadful cost of disease, on the one hand, and the great promise of modern scientific knowledge and techniques, on the other; and
7. A serious maldistribution of both personnel and facilities, so that some areas are disproportionately supplied in relation to others which suffer from an almost total lack of decent medical care;

Because prolonged failure effectively to relieve these shortages and to correct this maldistribution will result, inevitably, in the further extension of medical care directly by government agencies;

Because these conditions cannot effectively be remedied under the present system of payment for medical care, or under any voluntary insurance system;

Because a medical dole as an answer to this problem is repugnant to the American people and would certainly result in a system of state medicine, paid for from tax funds and rendered by regimented doctors,

The Congress declares the purpose of this Act to be:

(A) To relieve the shortage of qualified professional men and women by providing financial assistance to qualified educational institutions and by furnishing aid to the States to assist qualified students, through scholarships awarded without regard to race, color, or creed, to obtain education and training for these professions;

(B) To expand our knowledge concerning the causes, cure, and prevention of those diseases which take heavy toll of life and productivity, by furnishing financial aid to scientific research in these fields;

(C) To relieve the shortage of health facilities by extending existing legislation aiding the construction of such facilities and by adapting the provisions of that legislation so that localities in greatest need of such facilities shall receive more adequate assistance;

(D) To recognize the especially acute shortage of health facilities and personnel in rural areas and the desire of many rural people and their organizations to assume responsibility for obtaining such personnel and facilities by extending additional aid to such areas and by assisting rural health cooperatives on an experimental basis;

(E) To make the benefits of preventive medicine and of sanitation accessible to all our people by extending the well-established policy of grants-in-aid to the States for public health services so as to make modern health departments and preventive services available in every part of the country as promptly as possible;

(F) To encourage research into matters pertaining to the health and welfare of children and to further protect maternity and promote the health of our children by enabling the Children's Bureau to conduct and promote such research and by extending aid to the States for the expansion and improvement of maternal care and of services for the health of infants and children;

(G) To provide a sound economic foundation for our free system of medicine and to correct the maldistribution of health personnel and facilities by establishing a system of Prepaid Personal Health Insurance on the principle of Social Insurance.

SEC. 3. In establishing a system of National Health Insurance, it is the policy of this Act that those persons and their dependents who are insured under the provisions of the Act shall pay for its benefits in proportion to their incomes, and shall, therefore, receive its benefits as a right and not as charity; that they shall be assured full freedom to choose their physicians and to change their choice as they may desire; that physicians and other professions furnishing services in accordance with the provisions of this Act shall be assured full freedom in the practice of their professions, including the right to accept or reject patients except as this right may be restricted by their own professional ethics or by the laws of the several States; and that the administration of this Act shall be based upon the American principle of decentralization.

SEC. 4. In carrying out these policies, it is the intention of Congress that the major administrative responsibility be placed in the hands of local bodies representing both those who pay for and receive services and those who render services, and operating within the framework of plans made by the several States, and approved by the Federal agency; that the Personal Health Services Account created by this Act shall be allotted equitably among the several States and by the States to their local areas; that voluntary as well as governmental organizations shall be recognized and utilized; and that all employed and self-employed persons and their dependents as specified in title VII of this Act shall be entitled to its benefits without discrimination because of race, color, or creed.

TITLE I—EDUCATION OF HEALTH PERSONNEL

PART A—EDUCATION IN THE MEDICAL, DENTAL, DENTAL HYGIENE, PUBLIC HEALTH, NURSING, SANITARY ENGINEERING, HOSPITAL ADMINISTRATION, AND RELATED PROFESSIONS

SEC. 101. Title III of the Public Health Service Act, as amended (42 U. S. C., ch. 6A, subch. II), is amended by adding at the end thereof the following new part:

"PART H—ASSISTANCE FOR THE EDUCATION OF PROFESSIONAL HEALTH PERSONNEL

"DECLARATION OF POLICY

"SEC. 371. The Congress hereby finds and declares that—

"(a) there is a shortage of physicians, dentists, dental hygienists, nurses, sanitary engineers, and other health personnel (including hospital administrators) essential to maintaining and improving the Nation's health and this shortage is likely to increase unless present facilities and opportunities for training such personnel are strengthened and expanded;

"(b) the cost of providing adequate professional training, and facilities therefor, is so high and the sources of income for schools affording such training are so limited as to render it impossible for such schools to operate at present capacity on a financially sound basis, and as to discourage the construction and equipment of new schools and the expansion of existing schools necessary to relieve the shortage of professionally trained personnel; and

"(c) many qualified individuals, particularly members of minority population groups, are unable to obtain adequate professional training under present conditions; and

"(d) it is, therefore, the policy of the United States to take such steps and to utilize such of its resources as are necessary to provide adequate numbers of persons trained in the medical, nursing, dental, dental hygiene, sanitary engineering, hospital administration, and public-health professions (1) by assisting schools which provide such training in meeting their costs of instruction and by giving financial assistance for the construction and equipment of new schools and the expansion of existing schools, with a view to providing opportunities for more qualified individuals to obtain such training regardless of their race, creed, color, or national origin, and (2) by providing scholarships to induce greater numbers of qualified students to train for such professions and to equalize the opportunities for obtaining such training.

"PAYMENTS TO SCHOOLS FOR COSTS OF INSTRUCTION

"SEC. 372. (a) In order to assist schools of medicine, dentistry, dental hygiene, nursing, public health, and sanitary engineering to maintain and increase their enrollments of students, there is hereby authorized to be appropriated for the fiscal year ending June 30, 1950, and for each fiscal year thereafter such sums as may be necessary to make the payments provided in this section. Payments to schools from appropriations under this section may be used to meet the costs (herein referred to as 'costs of instruction') of establishing, maintaining, and enlarging their staffs and of maintaining and operating their facilities (including the acquisition of equipment).

"(b) Payments to schools for the fiscal year ending June 30, 1950, and for each of the two succeeding fiscal years shall be based on the number of students enrolled therein for such fiscal year as follows:

"(1) to each school of medicine which provides training leading to a degree of doctor of medicine, $300 for each student enrolled for such training up to its average past enrollment, and $1,700 for each student so enrolled in excess of its average past enrollment;

"(2) (A) to each school of dentistry which provides training leading to a degree of doctor of dental surgery or an equivalent degree, $250 for each student enrolled for such training up to its average past enrollment, and $1,300 for each student so enrolled in excess of its average past enrollment, and (B) to each school of dental hygiene which provides training leading to a diploma or degree as dental hygienist, $150 for each student enrolled for such training up to its average past enrollment, and $800 for each student so enrolled in excess of its average past enrollment;

"(3) to each school of nursing (A) which provides basic or advanced training leading to a degree in nursing, $200 for each student enrolled for such training up to its average past enrollment, and $1,200 for each student so enrolled in excess of its average past enrollment; or (B) which provides basic training leading to a diploma as a professional nurse, and which provides tuition, books, and other facilities and services needed in such training and board and lodging during such training to all students without charge therefor, $200 for each student enrolled in the first year of training, $150 for each student enrolled in the second year of training, and $50 for each student enrolled in the third year of training;

"(4) to each school of public health which provides training leading to a graduate degree in fields relating to public health (including hospital administration), $350 for each student enrolled for such training up to its average past enrollment, and $2,400 for each student so enrolled in excess of its average past enrollment; and

"(5) to each school of engineering which provides training leading to a degree in sanitary engineering or an equivalent degree, $200 for each student enrolled for such training up to its average past enrollment, and $1,200 for each student so enrolled in excess of its average past enrollment.

Payments under this section for the fiscal year ending June 30, 1953, and for each fiscal year thereafter shall be in such amounts as may be determined by the Congress in consideration of the findings and recommendations made on the basis of the surveys and studies authorized pursuant to subsection (f) of this section. The total payment to any school, other than a school of nursing which provides basic training leading to a diploma as a professional nurse, pursuant to this section for any fiscal year shall not exceed 50 per centum of the amount determined by the Surgeon General to be costs of instruction in such school for such year (excluding from such costs the cost of operation of any hospital and the cost of research projects).

"(c) The average past enrollment of any school shall be the average of its enrollments for the period consisting of the three fiscal years ending June 30, 1947, June 30, 1948, and June 30, 1949. If the number of years of training offered by a school during one or more of the fiscal years in such period is less than the number of years of training offered by the school during the fiscal year for which payment is to be made, the enrollment for such one or more of such preceding fiscal years shall be excluded in determining the school's average past enrollment, and if all such preceding fiscal years are thereby excluded, the school shall be paid for each student enrolled therein, in lieu of the sums specified in subsection (b), an amount equal to one-half of the sum therein specified as payable with respect to students in excess of the school's average past enrollment.

"(d) For purposes of this section, the number of students enrolled for training in a school for a fiscal year (and a school's enrollment for a fiscal year) means the number enrolled full time in such school for such training, as determined by the Surgeon General in accordance with regulations, for the first semester which commences after the beginning of such fiscal year, except that in the case of schools of dental hygiene only students enrolled full time in the first two years of training offered by such schools shall be counted.

"(e) A medical, dental, dental hygiene, nursing, public health, or engineering school shall be eligible for payments under this part if it is a public or nonprofit institution within the continental United States exempt from Federal income taxation, and if it has been approved or accredited by a body or bodies approved for such purpose by the Surgeon General after consultation with the National Council on Education for Health Professions (hereafter in this part called the 'Council').

"(f) The Surgeon General shall conduct or arrange for such surveys and studies as he deems appropriate to provide all necessary information relating to methods for carrying out the purposes of this part, including studies of the financial condition of schools providing education in the health professions, and the relationship of their financial condition to their capacity to maintain and expand student enrollment, and studies of the educational costs of such schools and of feasible means of calculating such costs on a uniform or comparable basis. By not later than January 1, 1952, the Surgeon General, through the Administrator, shall report to the Congress his findings based on such surveys and studies, together with appropriate legislative recommendations for the amendment of this part, including recommendations as to needed adjustments in the amounts specified in this section.

"APPROPRIATIONS FOR GRANTS FOR CONSTRUCTION AND EQUIPMENT

"SEC. 373. (a) There are also authorized to be appropriated from time to time such sums as may be necessary to enable the Surgeon General to make grants for construction and equipment to assist in the establishment of new schools and improvement and expansion of existing facilities (including teaching hospitals and other related facilities and including equipment thereof) necessary to carry out the purposes of section 371. The Surgeon General, after consultation with the Council, shall make such grants in the order of the estimated importance or value of the construction and equipment in alleviating the shortage of personnel adequately trained in the medical, nursing, dental, dental hygiene, sanitary engineering, and public-health fields. No such grant—

"(1) shall (except as provided in subsection (b)) be in excess of 50 per centum of the cost of the construction and equipment with respect to which it is made;

"(2) shall be made with respect to any construction and equipment for which application is not submitted, in accordance with the provisions of this part, prior to July 1, 1955.

"(b) If an application meeting the requirements of section 374 (b) is filed, no payments from appropriations under this section shall be made with respect thereto if it is in connection with the construction and equipment of any facility or part of a facility which constitutes a 'hospital' as defined in section 631 (e) of this Act unless an application is also made under section 625 of this Act for Federal assistance in the cost of such construction and equipment, and such application is approved under such section. The determination of the Surgeon General and the State agency (designated pursuant to section 623 (a)) whether to approve such application shall be made without regard to the project's priority or inclusion in a State construction program, and without regard to the availability of funds from the State's allotment under section 624. Federal payments with respect to the construction and equipment of such project—

"(1) shall be made from appropriations pursuant to this section and not from appropriations pursuant to title VI;

"(2) shall be made in amounts, in the manner, and subject to the same conditions as is provided for payments under section 625;

"(3) shall not reduce the unobligated portion of the State's allotment under section 624; and

"(4) shall be subject to recapture as provided in section 625 (e).

"CONDITIONS FOR GRANTS

"SEC. 374. (a) No payments from appropriations pursuant to section 372 for any fiscal year may be made to any school unless such school has filed an application therefor for such year which contains adequate assurance, as determined by the Surgeon General, that—

'(1) such school does not and will not impose any unreasonble restrictions against the admission of out-of-State students; and

"(2) such school will submit from time to time such reports as the Surgeon General may find necessary to carry out the purposes of this part, and will comply with such other conditions as may, subject to the provisions of section 382, be prescribed in regulations.

"(b) Payments from appropriations under section 373 may not be made for the construction and equipment of any new school or of any addition to an existing school except upon the filing of an application therefor which the Surgeon General determines contains adequate assurances that the school will, upon completion of the construction and equipment and for a period of ten years thereafter, (1) be operated as a public or nonprofit institution exempt from Federal income taxation, (2) be approved or accredited by a body or bodies approved for the purpose by the Surgeon General after consultation with the Council, and (3) comply with the provisions of subparagraph (1) of subsection (a) of this section.

"(c) No payments shall be made to any school from appropriations under section 372 or 373, unless the Surgeon General finds that such school admits (or, in the case of a new school, will admit) students without discrimination on the basis of race, creed, color, or national origin, except that, in the case of schools located within a State in which separate facilities are required by law to be maintained for separate racial groups, such payments may be made to schools which admit members of the minority racial groups, and may be made to any school which does not or will not admit members of the minority racial groups if the Surgeon General finds that there are comparable opportunities for qualified members of such racial groups who reside in the State to obtain the type of professional training offered by such school. As used in this section, 'minority racial group' means any race or racial group whose members constitute a minority of the population of the continental United States.

"PAYMENTS AND WITHHOLDING OR RECAPTURE OF PAYMENTS

"SEC. 375. (a) The Surgeon General, in accordance with regulations, shall determine from time to time the amount to be paid to each school under this part and shall certify to the Secretary of the Treasury the amounts so determined. Upon receipt of any such certification, the Secretary of the Treasury shall, prior to audit or settlement by the General Accounting Office, pay in accordance with such certification.

"(b) Whenever the Surgeon General, after reasonable notice and opportunity for hearing to a school, finds with respect to payments from appropriations under section 372 or 373 that there is a failure to carry out any assurances given pursuant to section 374 or to comply with regulations under this part, the Surgeon General shall notify such school that further payments will not be made to it from appropriations under such section until he is satisfied that there is no longer any such failure. Until he is so satisfied the Surgeon General shall make no further certification for payments to such school from appropriations under such section.

"(c) If any school with respect to which payments have been made from appropriations under section 373 for the construction and equipment of any building or other facility (other than one to which subsection (b) of such section is applicable) shall, within ten years after the completion of such construction, fail to carry out any assurances given pursuant to section 374 (b), the United States shall be entitled to recover from the owners of such building or other facility the same percentage of the then value of such building or facility as the amount paid with respect thereto from appropriations under section 373 was of the total cost of such building or facility, such value to be determined by agreement of the parties or by action brought in the district court of the United States for the district in which such building or facility is located.

"APPROPRIATIONS AUTHORIZED FOR SCHOLARSHIPS

"SEC. 376. In order further to increase the number of persons adequately trained in the fields of medicine, dentistry, dental hygiene, nursing, public health, including hospital administration, and sanitary engineering, there are hereby authorized to be appropriated for the fiscal year ending June 30, 1950, and for each fiscal year thereafter such sums as Congress may determine to be necessary for the purpose of enabling the Surgeon General to make payments to the States to cover the costs of the State scholarships awarded to persons pursuant to this part. The total number of such scholarships in each such field which may be awarded for any fiscal year shall be determined by the Surgeon General in accordance with regulations designed, insofar as practicable, to assure that the scholarship program under this section will keep pace with the progress made in the expansion of the staff and facilities of the schools providing training in such field.

"APPORTIONMENTS TO STATES FOR SCHOLARSHIPS

"SEC. 377. (a) Of the sums appropriated pursuant to section 376 for a fiscal year, such amounts as the Surgeon General shall determine, after consultation with the Council and consideration of the relative need for and cost of scholarships in each of the health fields, shall be available for—

"(1) scholarships to schools of medicine providing training leading to a degree of doctor of medicine;

"(2) scholarships to schools of dentistry providing training leading to a degree of doctor of dental surgery or an equivalent degree;

"(3) scholarships to schools of dental hygiene providing training leading to a diploma or degree as dental hygienist;

"(4) scholarships to schools of nursing providing basic or advanced training leading to a degree in nursing;

"(5) scholarships to schools of public health providing training leading to a graduate degree in fields relating to public health;

"(6) scholarships to schools of engineering providing training leading to a degree in sanitary engineering or an equivalent degree.

"(b) For each fiscal year, the Surgeon General shall from time to time apportion each of the sums available for apportionment pursuant to subparagraphs (1), (2), (3), (4), (5), and (6), respectively, of subsection (a) among the States having State plans approved under this part as follows: (1) One-half of each such sum on the basis of population (according to the latest figures available from the Department of Commerce), and (2) one-half of each such sum on the basis of the relative need of each such State for additional personnel trained in the field for which such sum is available, such need to be determined in accordance with regulations prescribed after consultation with the Council.

"(c) In any case in which the amount apportioned to a State from the sums available therefor pursuant to any subparagraph of subsection (a) is less than is necessary to provide two scholarships such amount shall be increased to the extent necessary to do so. Sums necessary for such increases are hereby authorized to be appropriated, and the limitation on the total number of scholarships established pursuant to section 376 shall be increased to the extent necessary to provide the increases authorized by the preceding provisions of this subsection.

"STATE PLANS FOR SCHOLARSHIPS

"Sec. 378. (a) To be approved under this part, a State plan for scholarships must—

"(1) establish or designate a single State agency as the sole agency for carrying out or supervising the carrying out of the State plan;

"(2) provide that the State agency shall make such reports, in such form and containing such information, as the Surgeon General may from time to time require, and comply with such provisions as the Surgeon General may find necessary to assure the correctness and verification of such reports;

"(3) provide that the sums received under this part shall be used exclusively for paying the cost of scholarships at school of medicine, dentistry, dental hygiene, nursing, public health, or engineering, as the case may be, in accordance with this part;

"(4) provide for the selection of appointees to scholarship on the basis of ability and such other factors as the State may find necessary and reasonable to carry out the purposes of this part;

"(5) provide that the selection of appointees for scholarships will be made without discrimination on the basis of race, color, creed, or national origin; and

"(6) provide that the scholarship to which a person is appointed shall include the cost of tuition customarily charged by the school, educational fees, books, and equipment, shall be for a period of time not in excess of that customarily required for completion of the standard course offered by the school, and shall include the cost of maintenance in such amount as the Surgeon General, after consultation with the Council, determines for each school, but not exceeding $125 per month for a student without dependents, $150 per month for a student with one dependent, and $175 per month for a student with two or more dependents: *Provided*, That any appointee to a scholarship who is able to do so financially shall be encouraged but not compelled to forego all or any part of such scholarship.

"(b) The Surgeon General, after consultation with the Council, shall approve any State plan which he finds meets the requirements of subsection (a) and is otherwise in conformity with the requirements of this part.

"CONDITIONS FOR AWARD OF SCHOLARSHIPS

"Sec. 379. (a) No scholarship shall be awarded by any State to any individual from funds paid to the State under this part unless he files an application therefor, in such form and containing such information as may be prescribed by regulations, including (1) a statement by the applicant as to whether he has or has not theretofore received a scholarship under this part; (2) a statement of the course of study or training proposed to be taken by the applicant; (3) a statement by the applicant showing whether the scholarship applied for is necessary to such undertaking; (4) a statement that the scholarship will be used to defray the costs of tuition fees, books, supplies, board, lodging, and other expenses (for himself and any dependents) incident to such course of study or training; and (5) the name and location of the educational institution which the applicant expects to attend.

"(b) Any student to whom a State agency has awarded a scholarship shall be entitled to continue receiving the amounts thereby provided for only so long as his work continues to be satisfactory, according to the regularly prescribed standards and practices of the educational institution which he is attending.

"(c) (1) No scholarship shall be awarded to any person for any period during which he is receiving education and training under title II of the Servicemen's Readjustment Act of 1944, as amended.

"(2) Scholarships awarded under this part shall be conditioned upon (a) acceptance by a school of his choice which provides the training for which the scholarship is awarded and which is accredited by a body or bodies approved by the Surgeon General for the purpose, and (b) agreement by the appointee to serve, upon completion of his training (including internships and residencies), one year for each two academic years during which he received the benefits of the scholarship (i) in the rendition for the State which selected him, or for a political subdivision thereof, of service in his profession or in the practice of his profession in an area designated by the State agency (carrying out or supervising the carrying out of the State plan approved under this part) as one in need of additional personnel trained in such profession, or (ii) with the approval of the State agency, in the practice of his profession on full time active duty in a medical agency or unit of the United States. If the appointee fails to fulfill his agreement, or if he voluntarily fails to complete the course of training covered by his scholarship and any required period of internship, he shall, unless he shows to the satisfaction of the State agency good cause for his failure, be obligated to reimburse the United States for the cost (reduced in proportion to the extent to which he has fulfilled his agreement) of the sums paid to him pursuant to this part.

"PAYMENTS TO STATES FOR SCHOLARSHIPS

"Sec. 380. (a) The Surgeon General shall from time to time estimate the sums to which each State is entitled from its apportionments under section 377 and shall certify to the Secretary of the Treasury the amount so estimated, reduced or increased, as the case may be, by any sum by which the Surgeon General finds his estimate for any prior period was greater or less than the amount which should have been paid to the State for such period. The Surgeon General shall also from time to time estimate the amount necessary for the proper and efficient administration of the State plan approved under this part for the period for which such estimate is made and shall certify to the Secretary of the Treasury one-half of the amount so estimated, reduced, or increased, as the case may be, by any sum by which the Surgeon General finds his estimate for any prior period was greater or less than the amount expended for such purpose for such period. The Secreary of the Treasury shall thereupon, through the Fiscal Service of the Treasury Department and prior to audit or settlement by the General Accounting Office, pay to the State the amounts so certified, at the time or times specified by the Surgeon General.

"(b) If the Surgeon General after reasonable notice and opportunity for hearing to the State agency carrying out or supervising the carrying out of the State plan approved under section 378 finds that there is a failure to comply substantially with any of the provisions of the State plan or regulations under this part, or that the State plan has been so changed that it no longer complies with the provisions of this part, he shall notify such State agency that further payment will not be made to the State from sums appropriated pursuant to section 376 or that payment will be limited to fields in which there is no such failure, until he is satisfied that there is no longer any such failure. Until he is so satisfied, he shall make no further certification to the Secretary of the Treasury, with respect to such State from such appropriations or shall limit certifications with respect to such State to fields in which there is no such failure.

"REGULATIONS

"Sec. 381. All regulations with respect to payments under this part to schools of medicine, schools of dentistry, schools of dental hygiene, schools of nursing, schools of public health, and schools of engineering, and to the States, shall be made only after consultation with the Council.

"GENERAL PROVISIONS

"Sec. 382. (a) Except as otherwise provided in this part, nothing contained in this part shall be construed as authorizing any department, agency, officer, or employee of the United States to exercise any control over, or prescribe any requirements with respect to, the curriculum or administration of any school, or the admission of applicants thereto.

"(b) Nothing in this part shall be construed to authorize the Surgeon General or any State agency to exercise any influence upon the choice by any applicant for, or a recipient of, a scholarship under this part of a course of training or study or of the educational institution at which such course is to be pursued, or to authorize the Surgeon General to exercise any supervision or control over any such institution for the purposes of this part."

NATIONAL COUNCIL ON EDUCATION FOR HEALTH PROFESSIONS

SEC. 102 (a) Section 217 of the Public Health Service Act is amended by adding at the end thereof the following new subsection:

"(h) The National Council on Education for Health Professions shall consist of the Surgeon General, who shall serve as Chairman, the Commissioner of Education or his representative, the chief medical officer of the Veterans' Administration or his representative, a medical representative designated by the Secretary of Defense, who shall be ex officio members, and twenty members appointed without regard to the civil-service laws by the Surgeon General with the approval of the Administrator. The twenty appointed members shall be leaders in the field of medical sciences, education, or public affairs, and ten of the twenty shall be selected from leading authorities in the field of medical, dental, nursing, sanitary engineering, and public health education. Each appointed member of the Council shall hold office for a term of four years, except that any member appointed to fill a vacancy occurring prior to the expiration of the term for which his predecessor was appointed shall be appointed for the remainder of such term, and except that, of the members first appointed, five shall hold office for a term of three years, five shall hold office for a term of two years, and five shall hold office for a term of one year as designated by the Surgeon General at the time of appointment. None of such twenty members shall be eligible for reappointment until a year has elapsed since the end of his preceding term. The Surgeon General with the approval of the Administrator is authorized to appoint such special advisory and technical committees, including committees for medical, dental, dental hygiene, nursing, sanitary engineering, hospital administration, and public-health education, respectively, as may be useful in carrying out the functions of the Council and the Service under part H of title III of this Act."

PART B—PRACTICAL NURSE TRAINING

DEFINITIONS

SEC. 111. When used in this part—

(a) The term "practical nurse" means a person who is trained to care for subacute, convalescent, and chronic patients under the direction of a licensed physician or under the supervision of a registered professional nurse, or to assist a registered professional nurse in the care of acute illness.

(b) The term "State" includes the several States, Alaska, Hawaii, Puerto Rico, the Virgin Islands, and the District of Columbia.

(c) The term "Administrator" means the Federal Security Administrator.

(d) The term "Commissioner" means the Commissioner of Education of the Federal Security Agency.

(e) The term "State board" means the State Board for Vocational Education.

STATE PLANS

SEC. 112. (a) In order for a State to secure the benefits of this part, the State board shall submit, and have approved by the Commissioner, a State plan for practical nurse training. To be approved under this part, a State plan for practical nurse training must provide (1) that such training shall be given under public supervision or control; (2) that the purpose of such training shall be to fit individuals for useful employment as practical nurses; (3) that such training shall be of less than college grade and shall be designed to meet the needs of persons over sixteen years of age who are preparing to enter upon or who have entered upon the vocation of practical nursing; (4) that such training shall include such courses of practical training and instruction and such supervised experience as are necessary to meet the minimum requirements of State licensing laws for practical nurses, or, where such laws have not been enacted, that the State board shall establish adequate standards for such training and instruction; (5) that teachers of practical nurse courses in any State shall have at least the minimum qualifications for teachers of such subjects determined upon for such State by the State board, with the approval of the Commissioner; (6) for the availability of professional education courses necessary for the certification of teachers, supervisors, and directors of practical nurse training; (7) that such training leading to certification of teachers, supervisors, and directors shall be given under the auspices of the State board and, except in the case of teachers of related subjects, only to persons who have had adequate experience in nursing; (8) duties and qualifications for teachers, teacher-trainers, supervisors and directors, and plans for the supervision and direction of practical nurse training; (9) for an advisory council composed of not more than ten nor less than six persons, including not less than two registered nurses, a physician, an educator, a hospital administrator, and such other persons the State may desire, all of whom shall be appointed for overlapping terms of not to exceed three years; (10) that the State treasurer (or similar officer) shall be custodian of funds paid to the State under this part and shall pay such funds only on requisition of the State board to such schools as are approved by the Board and are entitled to receive payments under the plan; (11) evidence satisfactory to the Commissioner that full compliance with the requirements of this part is authorized under the State laws; (12) that the State board shall make an annual report to the Commissioner on or before September 1 of each year, on such forms and in such manner as the Commissioner may prescribe, on the work done in the State during the preceding fiscal year and the receipts and expenditures of money under the State plan approved under this part.

(b) The Commissioner shall approve any plan which fulfills the conditions specified in subsection (a) and which he finds is otherwise in conformity with the provisions and purposes of this part; and (13) that the State board has all the authority necessary to carry out the State plan and to cooperate with the Commissioner in the administration of this part.

AUTHORIZATIONS FOR APPROPRIATIONS

SEC. 113. (a) For the purpose of assisting the several States in the development of practical nurse training, there is authorized to be appropriated for the fiscal year beginning July 1, 1949, and annually thereafter, $15,000,000 for expenditure in accordance with the provisions of this part.

(b) There is also authorized to be appropriated for the fiscal year beginning July 1, 1949, and annually thereafter, such amount as may be necessary for the administration of this part.

(c) The funds appropriated pursuant to subsection (a) may be used for assisting the several States in meeting the direct costs of maintaining an adequate program of administration, supervision, and teacher-training; for salaries and necessary travel expenses of teachers, teacher-trainers, supervisors, and directors of practical nurse training and for necessary travel expenses of students taking practical training in a hospital outside the community in which the school is located; for securing necessary educational information and data as a basis for the proper development of programs of practical nurse training; for purchase, rental, or other acquisition and the repair and maintenance of equipment for vocational instruction; for purchase of supplies for vocational instruction; for the costs of operation of necessary buildings; to provide initially for alteration of public buildings to facilitate such training (not to exceed $2,500 per training unit); for promotion of the program and recruitment of students and teachers; for paying the cost of practical nurse training, under the supervision or control of the State board or local boards of vocational education, in public or nonprofit private hospitals exempt from income tax under section 101 of the Internal Revenue Code: *Provided*, That all expenditures for the purposes set forth in this section shall be made in accordance with the State plan approved under this part.

REQUIREMENTS AS TO MATCHING OF FUNDS

SEC. 114. In order to receive the benefits of this part for any period after June 30, 1954, each State shall be required to match by State or local funds, or both: (a) for the two-year period ending June 30, 1956, 25 per centum of the amount expended during such period by the State from funds paid to it under this part; (b) for the two-year period ending June 30, 1958, 50 per centum of the amount so expended during such period; (c) for any fiscal year thereafter, 100 per centum of the amount so expended during such period.

PAYMENTS TO STATES

SEC. 115. (a) Of the amount appropriated for each fiscal year pursuant to section 113 (a), 50 per centum shall be allotted by the Commissioner among the States having State plans approved prior to the beginning of such year, in the proportion which the population of each such State bears to the population of all the States having State plans so approved. The remaining 50 per centum of such amount shall be allotted by the Commissioner among such of the States having approved State plans as he determines, under regulations prescribed by him with the approval of the Administrator, can make the most efficient use of such funds for the purposes of this part.

(b) From time to time the Commissioner shall certify to the Secretary of the Treasury for payment to each State such amounts, within the allotment to such State, as shall be necessary to carry out the approved State plan. Upon receipt of any such certification, the Secretary of the Treasury shall, prior to audit or settlement by the General Accounting Office, pay in accordance with said certification.

(c) Funds appropriated pursuant to this part shall not be paid to any State until a State supervisor of practical nurse training meeting the minimum requirements established in the State plan has been employed.

REGULATIONS

SEC. 116. The Commissioner, with the approval of the Administrator, shall make and publish such regulations, not inconsistent with this part, as may be necessary to the efficient administration of its provisions.

ADMINISTRATION

SEC. 117. The Commissioner shall perform his functions under this part under the supervision and direction of the Administrator. It shall be the duty of the Commissioner to make, or cause to have made, studies, investigations, and reports for use in aiding the States in training practical nurses and teachers, teacher-trainers, supervisors, and directors of practical nurse training.

ANNUAL REPORT

SEC. 118. The Commissioner shall make an annual report to the Administrator concerning the administration of this part, including reports to show the distribution of Federal funds, the activities of the States in the training program, the numbers of persons trained thereunder, and recommendations for such revisions of this part as he deems necessary. The Administrator shall include in his annual report to the Congress such portions of the Commissioner's report as the Administrator deems necessary.

ADVISORY COMMITTEES

SEC. 119. The Commissioner may, with the approval of the Administrator, appoint such advisory committees on practical nurse training as he deems necessary to the proper administration of this part. The members of such committees who are not officers or employees of the United States shall serve without compensation, except that while attending conferences or meetings of the committees or while otherwise serving at the request of the Commissioner they shall be entitled to receive compensation at a rate to be fixed by the Commissioner, but not exceeding $50 per diem, and shall also be entitled to receive an allowance for actual and necessary travel and subsistence expenses while so serving away from their places of residence.

WITHHOLDING OR RECAPTURE OF PAYMENTS

SEC. 120. (a) Whenever any portion of the funds paid to any State under this part has not been expended in accordance with its provisions, a sum equal to such portion shall be deducted by the Commissioner from subsequent payments hereunder to such State and the State shall be held accountable for the full amount so paid plus an amount equal to that withheld.

(b) The Commissioner may withhold the allotment or payment of any moneys to any State under this part whenever he determines that such moneys are not being expended in accordance with the provisions of this part.

(c) If any portion of the moneys paid to any State under this part shall, by any action or contingency be diminished or lost, it shall be replaced by such State, and until so replaced no subsequent payments shall be made to such State under this part. No funds paid to a State under this part shall be applied, directly or indirectly, to the purchase, erection, preservation, or repair (other than alterations) of any building or buildings, or for the purchase or rental of lands, or for payment (except as provided in section 113 (c)) to any privately owned or conducted school, college, or other institution.

TITLE II—MEDICAL RESEARCH

PURPOSE

SEC. 201. The purpose of this title is to improve the health of the people of the United States through the conduct of researches, investigations, experiments, and demonstrations relating to the cause, prevention, and methods of diagnosis and treatment of poliomyelitis, diabetes, arthritis and rheumatism, multiple sclerosis, cerebral palsy and epilepsy, and other disease or groups of diseases; assist and foster such researches and other activities by public and private agencies, and promote the coordination of all such researches and activities and the useful application of their results; provide training in matters relating to such diseases; and develop, and assist States and other agencies in the use of, the most effective methods of prevention, diagnosis, and treatment of such diseases.

ADDITIONAL RESEARCH INSTITUTES

SEC. 202. (a) The heading of title IV of the Public Health Service Act (42 U. S. C., ch. 6A) is amended to read "Title IV—National Research Institutes",

(b) Title IV of such Act is further amended by adding immediately after part C the following new part:

"PART D—OTHER INSTITUTES

"ESTABLISHMENT OF INSTITUTES

"SEC. 431. The Surgeon General is authorized, with the approval of the Administrator, to establish in the Public Health Service one or more additional institutes to conduct and support scientific research and professional training relating to the cause, prevention, and methods of diagnosis and treatment of poliomyelitis, diabetes, arthritis and rheumatism, multiple sclerosis, cerebral palsy and epilepsy, or any other diseases or groups of diseases whenever the Surgeon General determines that such action is necessary to effectuate fully the purposes of section 301 with respect to such disease or diseases. Any institute so established may in like manner be abolished and its functions transferred elsewhere in the Public Health Service upon a finding by the Surgeon General that a separate institute is no longer required for such purposes.

"ESTABLISHMENT OF NATIONAL ADVISORY COUNCILS

"SEC. 432. Upon the establishment of an institute pursuant to section 431, the Surgeon General is also authorized to establish a national advisory council to advise, counsult with, and make recommendations to the Surgeon General on matters relating to the activities of the institute. Any such council shall consist of the Surgeon General ex officio, and of twelve members appointed without regard to the civil-service laws by the Surgeon General with the approval of the Administrator. The twelve appointed members shall be leaders in the field of fundamental sciences, medical sciences, education, or public affairs, and six of such twelve shall be selected from leading medical or scientific authorities who are outstanding in the study, diagnosis, or treatment of the disease or diseases to which the activities of the institute are directed. Each appointed member of the council shall hold office for a term of four years except that any member appointed to fill a vacancy occurring prior to the expiration of the term for which his predecessor was appointed shall be appointed for the remainder of such term and except that, of the members first appointed, three shall hold office for a term of three years, three shall hold office for a term of two years, and three shall hold office for a term of one year, as designated by the Surgeon General at the time of appointment. None of such twelve members shall be eligible for reappointment until a year has elapsed since the end of his preceding term. Every two years the council shall elect one member to act as chairman for the succeeding two-year period.

"FUNCTIONS

"SEC. 413. Where an institute has been established under this part, the Surgeon General shall carry out the purposes of section 301 with respect to the conduct and support of research relating to the disease or diseases to which the activities of the institute are directed (including grants-in-aid for drawing plans, erection of buildings, and acquisition of land therefor) through such institute and in cooperation with the appropriate council. In addition, the Surgeon General is authorized to provide training and instruction and establish and maintain traineeships, in such institute and elsewhere, in matters relating to the diagnosis, prevention and treatment of such disease or diseases with such stipends and allowances (including travel and subsistence expenses) for trainees as he may deem necessary, and, in addition, provide for such training, instruction, and traineeships through grants to public and other nonprofit institutions. Upon the appointment of a national advisory council for an institute established under this part, such council shall assume the duties, functions, and powers of the National Advisory Health Council with respect to grants-in-aid for research and training projects relating to the disease or diseases to which the activities of the institute are directed."

NATIONAL ADVISORY COUNCILS

SEC. 203. (a) Subsection (b) of section 217 of the Public Health Service Act, is amended to read as follows:

"(b) The National Advisory Health Council shall advise, consult with, and make recommendations to the Surgeon General on matters relating to health activities and functions of the Service. The Surgeon General is authorized to utilize the services of any member or members of the Council and, where appropriate, any member or members of the national advisory councils established under this Act on cancer, dental research, mental health, heart, or other diseases or groups of diseases in connection with matters related to work of the Service, for such periods, in addition to conference periods, as he may determine."

(b) The heading of section 217 of such Act is amended to read "National Advisory Councils".

(c) Subsection (e) of section 208 of such Act is amended to read as follows:

"(e) Members of the National Advisory Health Council and members of other national advisory councils, established under this Act, other than ex officio members, while attending conferences or meetings of their respective councils or while otherwise serving at the request of the Surgeon General, shall be entitled to receive compensation at a rate to be fixed by the Administrator, but not exceeding $50 per diem, and shall also be entitled to receive an allowance for actual and necessary traveling and subsistence expenses while so serving away from their places of residence."

OTHER AUTHORITY

SEC. 204. Section 406 of the Public Health Service is amended to read as follows:

"OTHER AUTHORITY

"SEC. 406. This title shall not be construed as limiting (a) the functions or authority of the Surgeon General or the Public Health Service under any other title of this Act, or of any officer or agency of the United States, relating to the study of the prevention, diagnosis, and treatment of any disease or group of diseases for which a separate institute is established under this Act; or (b) the expenditure of money therefor."

(b) Sections 415, 425, and 426 of such Act are hereby repealed.

(c) Section 209 of such Act is amended by adding at the end thereof the following new subsection:

"(g) The Administrator is authorized to establish and fix the compensation for, within the Public Health Service, not more than thirty positions, in the professional and scientific service, such position being established to effectuate those research and development activities of the Public Health Service which require the services of specially qualified scientific or professional personnel: *Provided*, That the rates of compensation for positions established pursuant to the provisions of this subsection shall not be less than $10,000 per annum nor more than $15,000 per annum, and shall be subject to the approval of the Civil Service Commission. Positions created pursuant to this subsection shall be included in the classified civil service of the United States, but appointments to such positions shall be made without competitive examination upon approval of the proposed appointee's qualifications by the Civil Service Commission or such officers or agents as it may desigante for this purpose."

TITLE III—HOSPITAL SURVEY AND CONSTRUCTION AMENDMENTS

PURPOSE

Sec. 301. The purpose of this title is to amend the hospital survey and construction provisions of the Public Health Service Act so as to extend the duration of such provisions until June 30, 1957; to increase the amount authorized to be allotted among the States for assisting in meeting the costs of construction of hospitals; to authorize increases in the amount of Federal participation in the costs of construction of projects and permit variation of such amount within a State in accordance with State standards; to include in the program specifically, and to give necessary emphasis to construction of, facilities for group medical and dental practice; to authorize studies on the coordinated use of hospital facilities on a regional area basis; and to otherwise improve such provisions of the Public Health Service Act.

AMENDMENT OF PURPOSE OF SURVEY PROVISIONS

Sec. 302. Section 601 of the Public Health Service Act is amended to read:

"Sec. 601. The purpose of this title is—

"(a) to assist the several States to inventory their existing hospitals (as defined in section 631 (e)), to survey the need for construction of hospitals, and to develop programs for construction of such public and other nonprofit hospitals as will, in conjunction with existing facilities, afford the necessary physical facilities for furnishing adequate hospital, clinic, and similar services to all their people;

"(b) to assist in the construction of public and other nonprofit hospitals in accordance with such programs; and

"(c) to authorize the Surgeon General to conduct, and make grants for the conduct of, research, experiments, and demonstrations relating to the effective development and utilization of hospital services, facilities, and resources, and to promote the coordination of such experiments and demonstrations and the useful application of their results."

GRANTS FOR ADMINISTRATIVE EXPENSES OF STATE AGENCIES

Sec. 303. (a) The heading of part B of title VI of such Act is amended to read "Surveys, Planning, and Administration."

(b) Such part is further amended by adding at the end thereof the following new section:

"GRANTS FOR ADMINISTRATIVE EXPENSES OF STATE AGENCIES

"Sec. 614. (a) In order to assist the States in the continuous development and administration of State plans approved by the Surgeon General under section 623 (b), there is hereby authorized to be appropriated for the fiscal year ending June 30, 1950, and for each fiscal year thereafter, the sum of $1,000,000.

"(b) Each State for which a State plan has been approved under section 623 (b) prior to or during a fiscal year shall be entitled for such year to an allotment bearing the same ratio to the sums appropriated for such year under subsection (a) of this section as the State's allotment under section 624 bears to the total of the allotments made to all States under that section for such year: *Provided*, That no such allotment to any State shall be less than $15,000; and amounts required to pay such minimum allotments are hereby authorized to be appropriated in addition to the amounts authorized under subsection (a). The Surgeon General shall calculate the allotments to be made under this subsection and shall notify the Secretary of the Treasury of the amounts thereof.

"(c) The Surgeon General shall, from time to time, determine the amounts to be paid to each State from the allotments to such State under subsection (b), and shall certify to the Secretary of the Treasury the amounts so determined, reduced or increased, as the case may be, by the amounts by which he finds that estimates of required expenditures with respect to any prior period were greater or less than the actual expenditures of such period. Upon receipt of such certification, the Secretary of the Treasury shall, prior to audit or settlement by the General Accounting Office, pay in accordance with such certification.

"(d) The moneys so paid to any State shall be expended by or under the direction of the State agency designated pursuant to paragraph (1) of section 623 (a) and shall be expended solely to meet expenses incurred in the administration of the State plan approved under section 623 (b), including a continuous inventory of existing hospital facilities, surveys of the need for additional facilities, investigation of the need for financial assistance in the maintenance and operation of hospital facilities, and development of construction programs in accordance with section 601 (a). Moneys so paid shall be paid upon the condition that there shall be spent in such State for the same purpose from funds of such State an amount at least equal to the amount of funds paid to the State under this subsection."

(c) Money appropriated prior to July 1, 1949, pursuant to section 611 of the Public Health Service Act but not paid to any State prior to such date shall revert to the general funds in the Treasury of the United States. Money paid to any State prior to such date pursuant to section 613 (a) of such Act but not expended by it prior to such date shall be available to such State for expenses incurred in the administration of the State plan approved under section 623 (b) of such Act and shall be taken into account by the Surgeon General in determining the amounts to be paid to such State under section 614 of the Public Health Service Act, as amended by this Act.

APPROPRIATIONS

SEC. 304. The first sentence of section 621 of such Act is amended to read: "In order to carry out the purposes of section 601 (b) there are hereby authorized to be appropriated for the fiscal year ending June 30, 1950, and for each fiscal year thereafter, such sums as may be necessary to liquidate contractual obligations incurred pursuant to section 625."

GROUP PRACTICE FACILITIES

SEC. 305. Section 622 of such Act is amended by adding at the end thereof the following new subsection:

"(h) The extent to which and the conditions under which the State plan shall make provision for construction of facilities for the group practice of medicine or dentistry (or both) by or for a cooperative or other nonprofit corporation or association and for assignment of priority to such construction, regulations under this paragraph to be prescribed not later than six months after the enactment thereof."

STATE STANDARDS FOR VARIABLE GRANTS

SEC. 306. Section 623 of such Act is amended by adding after subsection (d) the following new subsection:

"(e) The State plan may include standards for determination of the Federal share of the cost of projects approved in the State. Such standards shall provide equitably (and, to the extent practicable, on the basis of objective criteria) for variations between projects or classes of projects on the basis of the economic status of areas, relative need as between areas for additional hospital facilities, and other relevant factors. No such standards shall provide for a Federal share of more than 66⅔ per centum or less than 33⅓ per centum of the cost of construction of any project. The Surgeon General shall approve any such standards and any modifications thereof which comply with the provisions of this subsection."

ALLOTMENTS TO STATES

SEC. 307. Section 624 of such Act is amended to read:

"SEC. 624. (a) Each State for which a State plan has been approved prior to or during a fiscal year shall be entitled for any such year which occurs prior to the fiscal year beginning July 1, 1957, to an allotment of a sum bearing the same ratio to $150,000,000 as the product of (1) the population of such State, and (2) the square of its allotment percentage (as defined in section 631 (a)) bears to the sum of the corresponding products of all of the States: *Provided*, That no such allotment to any State (other than the Virgin Islands) shall be less than $200,000. The Surgeon General shall calculate the allotments to be made under this section and notify the Secretary of the Treasury of the amounts thereof.

"(b) The amount of the allotment to a State shall be available in accordance with the provisions of this part for payment of the Federal share (as defined in section 631 (j)) of the cost of approved projects within such State. Sums allotted to a State for a fiscal year for construction and remaining unobligated at the end of such year shall remain available to such State for such purpose for the next fiscal year (and for such year only), in addition to the sums allotted to such State for such next fiscal year."

APPROVAL OF PROJECTS AND PAYMENTS FOR CONSTRUCTION

SEC. 308. Section 625 of such Act is amended to read:

"SEC. 625. (a) For each project for construction pursuant to a State plan approved under this part, there shall be submitted to the Surgeon General through the State agency an application for funds by the State or a political subdivision thereof or by a public or other nonprofit agency. If two or more of such agencies join in the construction of the project, the application may be filed by one or more of such agencies. Such application shall set forth (1) a description of the site for such project; (2) plans and specifications for the project in accordance with the regulations prescribed by the Surgeon General under section 622 (e); (3) a payee to receive payments from the State or the Secretary of the Treasury, who is duly authorized to receive such payments; (4) reasonable assurance that title, as defined in section 631 (k), to such site is or will be vested in one or more of the agencies filing the application, or in a public or other nonprofit agency which is to operate the hospital; (5) reasonable assurance that (i) adequate financial support will be available for the construction of the project, and (ii) the rates of pay for laborers and mechanics engaged in construction of the project will not be less than the prevailing local wage rates for similar work as determined in accordance with Public Law 403 of the Seventy-fourth Congress, approved August 30, 1935, as amended; (6) reasonable assurances that adequate financial support will be available for its maintenance and operation; and (7) a certification by the State agency of the Federal share for the project.

"(b) The Surgeon General shall approve such application if the unobligated balance of the sum allotted to the State is equal to or greater than the Federal share of the cost of construction of such project, and if the Surgeon General finds (1) that the plans and specifications are in accord with the regulations prescribed pursuant to section 622; (2) that the application is in conformity with the State plan approved under section 623; (3) that the application contains reasonable assurances as to title, financial support, and payment of prevailing rates of wages, as required in subsection (a); (4) that the application contains assurance that in the operation of the hospital there will be compliance with the applicable requirements of the State plan and of the regulations prescribed pursuant to section 622 (f) regarding provision of facilities without discrimination on account of race, creed, or color, and for furnishing needed hospital facilities for persons unable to pay therefor; (5) that the payee designated in the application has authority to receive payment for and on behalf of the agency or agencies responsible for the construction of the project; and (6) that it has been approved and recommended by the State agency and is entitled to priority over other projects within the State in accordance with the regulations prescribed pursuant to subsection (d) and (h) of section 622. No application shall be disapproved until the Surgeon General has afforded the State agency an opportunity for a hearing.

"(c) Whenever the Surgeon General shall have approved an application for a construction project in accordance with this section, the Federal share of the estimated cost of such project shall constitute a contractual obligation of the Federal Government.

"(d) Upon approving an application under this section, the Surgeon General shall certify to the Secretary of the Treasury an amount equal to the Federal share of the estimated cost of construction of the project and designate the appropriation from which it is to be paid. Such certification shall provide for payment to the State, except that, if the State agency so requests, the certification shall provide for payment direct to the payee designated in the application. Upon certification by the State agency, based upon inspection by it, that work has been performed upon a project, or purchases have been made, in accordance with the approved plans and specifications, and that payment of an installment is due, the Surgeon General shall certify such installment for payment by the Secretary of the Treasury. If the Surgeon General, after investigation or otherwise, has ground to believe that a default has occurred requiring action pursuant to section 632 (a) he may, upon giving notice of hearing pursuant to such subsection, withhold certification pending action based on such hearing.

"(e) Amendment of any approved application shall be subject to approval in the same manner as an original application. Certification under subsection (d) may be amended, either upon approval of an amendment of the application or upon revision of the estimated cost of a project. An amended certification may direct that any additional payment be made from the applicable allotment for the fiscal year in which such amended certification is made.

"(f) The funds paid under this section for the construction of an approved project shall be used solely for carrying out, or to make reimbursement for expenditures made in carrying out, such project as approved.

"(g) If any hospital for which funds have been paid under this section shall at any time within twenty years after the completion of construction (A) be sold or transferred to any person, agency, or organization (1) which is not qualified to file an application under this section, or (2) which is not approved as a transferee by the State agency designated pursuant to section 623 (a) (1), or its successor, or (B) cease to be a public or a nonprofit hospital as defined in section 631 (g), the United States shall be entitled to recover from the transferor or transferors (or, in the case of a hospital which has ceased to be a nonprofit hospital, the owners thereof) an amount bearing the same ratio to the then value of the hospital, or of that portion of the hospital constituing an approved project, as the amount of the Federal participation bore to the cost of construction of such project: *Provided*, That if the transfer of the hospital be involuntary, as by foreclosure, condemnation, or operation of law, the United States shall be entitled to recover an amount bearing a like ratio to the total amount of any proceeds thereof to which the transferer may be entitled: *Provided further*, That the United States shall in no case be entitled to recover an amount in excess of the amount of Federal participation in the cost of construction of any project. Such amount may be recoverable by action brought in the district court of the United States for the district in which such hospial is situated. The State agency shall no approve any person, agency, or organization as a transferee unless such person, agency, or organization gives the assurances required by section 625 (a) and (b) with respect to maintenance and operation of the hospital."

"DEFINITIONS

SEC. 309. (a) Subsection (e) of section 631 of such Act is amended to read:

"(e) the term 'hospital' (except when used in section 622 (a) and (b)) includes public health centers, facilities for the group practice of medicine or dentistry (or both) by or for a cooperative or other nonprofit corporation or association, and general, tuberculosis, mental, chronic disease, and other types of hospitals, and related facilities, such as laboratories, out-patient departments, nurses' home and training facilities, and central service facilities operated in connection with hospitals, but does not include any hospital furnishing primarily domiciliary care;".

(b) Subsection (g) of section 631 of such Act is amended to read:

"(g) the term 'nonprofit hospital' means any hospital which is owned by one or more nonprofit corporations or associations and which is operated by one or more nonprofit corporations or associations; and the term 'nonprofit corporation or association' means a corporation or association, no part of the net earnings of which inures, or may lawfully inure, to the benefit of any private shareholder or individual;".

(c) Such section is further amended by striking out "and" at the end of paragraph (h), by striking out the period at the end of paragraph (i) and inserting in lieu thereof a semicolon, and by inserting after paragraph (i) the following new paragraphs:

"(j) The term 'Federal share' with respect to any project means the proportion of the cost of construction of such project to be paid by the Federal Government under this part, the amount thereof to be determined as follows:

"(1) if the State plan for any State, as of the date of approval of any project application, contains standards approved by the Surgeon General pursuant to section 623 (e), the Federal share with respect to such project shall be determined by the State agency in accordance with such standards;

"(2) if the State plan does not contain such standards, the Federal share shall be an amount (not less than 33⅓ per centum and not more than either 66⅔ per centum or the State's allotment percentage, whichever is the lower) established by the State agency for all projects in the State: *Provided*, That each State agency shall give the Surgeon General written notification of the Federal share for projects approved in such State within each fiscal year prior to the approval of the first project in such State during such year, and the Federal share for such State for such year shall not be changed after such approval; and

"(k) The term 'title' means a fee simple, or such other estate or interest (including leaseholds) as the Surgeon General finds sufficient to assure undisturbed use and possession for a period of not less than fifty years for the purposes of construction and operation of the project."

WITHHOLDING OF CERTIFICATION

SEC. 310. Section 632 (a) of such Act is amended to read:

"(a) Whenever the Surgeon General, after reasonable notice and opportunity for hearing to the State agency designated in accordance with section 623 (a) (1) finds (1) that the State agency is not complying substantially with the provisions required by section 623 (a), or by regulations prescribed pursuant to section 622, to be contained in its plan submitted under section 623 (a), or (2) that any funds have been diverted from the purposes for which they have been allotted or paid, or (3) that any assurance given in an application filed under section 625 is not being or cannot be carried out, or (4) that there is a substantial failure to carry out plans and specifications approved by the Surgeon General under section 625, the Surgeon General may forthwith notify the Secretary of the Treasury and the State agency that no further certification will be made under part B or part C, or that no further certification will be made for expenses of administering the State plan or for any project or projects designated by the Surgeon General as being affected by the default, as the Surgeon General may determine to be appropriate under the circumstances; and, except with regard to any project for which the application has already been approved and which is not directly affected by such default, he may withhold further certifications until there is no longer any failure to comply, or, if compliance is impossible, until the State repays or arranges for the repayment of Federal moneys which have been diverted or improperly expended."

HOSPITAL FACILITIES

SEC. 311. Such Act is further amended by adding after section 635 the following new section:

"STUDIES AND DEMONSTRATIONS RELATING TO COORDINATED USE OF HOSPITAL FACILITIES

"SEC. 636. In carrying out the purposes of section 301 with respect to hospital facilities, the Surgeon General is authorized to conduct research, experiments, and demonstrations relating to the effective development and utilization of hospital services, facilities, and resources and, after consultation with the Federal Hospital Council, to make grants-in-aid to States, political subdivisions, universities, hospitals, and other public or private nonprofit institutions or organizations for projects for the conduct of research, experiments, or demonstrations relating to the development, utilization, and coordination of hospital services, facilities, and resources. Any award made under this section for any such project in any fiscal year may include amounts for not to exceed the four succeeding fiscal years, and such amounts for such succeeding fiscal years shall constitute contractual obligations of the Federal Government: *Provided*, That the total of such obligations for all such projects to be paid in any such succeeding fiscal year may not exceed $1,200,000."

EFFECTIVE DATES

SEC. 312. (a) This title shall take effect upon the date of its enactment, except that (1) section 624 (a) of the Public Health Service Act, as amended by section 307 of this Act, shall be effective as of July 1, 1948; and (2) section 624 (b) and the first sentence of section 625 (d) of the Public Health Service Act, as amended by sections 307 and 308 of this Act, respectively, shall be effective with respect to all projects approved under section 625 of the Public Health Service Act on or after January 1, 1949.

(b) Effective as of July 1, 1948, the paragraph "Grants for hospital construction" under the heading "Public Health Service" in the Federal Security Agency Appropriation Act, 1949, is amended by striking out "$75,000,000" and inserting in lieu thereof "$150,000,000".

(c) The Federal share of the cost of construction (determined pursuant to section 631 (j) of the Public Health Service Act, as amended by this Act) of any project with respect to which an application has been approved after August 13, 1946, and prior to the date of enactment of this Act, shall constitute a contractual obligation of the United States, notwithstanding that it may be in excess of the State's allotment determined in accordance with the applicable provisions of title VI of the Public Health Service Act and the applicable provisions of the Acts appropriating funds for the Federal Security Agency appropriation Acts. There are hereby authorized to be appropriated (in addition to the sums authorized to be appropriated pursuant to section 621 of the Public Health Service Act, as amended by this Act) such sums as may be necessary to meet the Federal share of the cost of construction of such projects in excess of States' allotments is herein provided. In no case shall the total of the Federal payments made before and the payments made after enactment of this Act with respect to any project approved under title VI of the Public Health Service Act exceed the Federal share of the cost of construction thereof.

SHORT TITLE

SEC. 313. This title may be cited as the "Hospital Survey and Construction Amendments of 1949".

TITLE IV—SPECIAL AID FOR RURAL AND OTHER SHORTAGE AREAS

PART A—RELIEF OF SHORTAGES IN RURAL AND OTHER AREAS

PURPOSE

SEC. 401. It is the purpose of this title, through grants and loans supplementing other titles of this Act, to expedite the provision of physicians, dentists, nurses, hospitals, clinics, and other requisites of adequate medical service, for the people in areas which are especially short of such personnel and facilities.

MEASURES AUTHORIZED

SEC. 402. (a) In the case of any area in any State (especially a rural area) which is determined to be an area in which shortages of personnel and facilities needed to provide personal health services under title VII would operate to make unavailable or to restrict disproportionately the availability of such services, the following measures may be taken in order to assist in relieving such shortages:

(1) Grants and loans to persons (as defined in section 781 (1) agreeing to furnish personal-health services, or to assist in the provision of such services, as benefits in shortage areas, as follows:

(A) grants in the form of guaranties of minimum gross or net incomes, or of payments to meet operating expenses or any part thereof (exclusive of acquisition costs of durable equipment), to qualified professional, technical, and administrative health personnel to encourage their location or continuation in shortage areas; and grants for the costs of transportation of such personnel, their families, household goods, or the costs of similar or related items necessary for such location;

(B) grants, to aid in maintenance and operation, to local facilities for group practice, health centers, clinics, and hospitals;

(C) loans, for the cost of facilities (including construction and durable equipment), to qualified professional and technical health personnel, including organized groups of such qualified individuals, to encourage their location or continuation in shortage areas; such loans to bear interest at the rate of 2 per centum per annum, and to be repayable to the United States within ten years;

(D) grants, and loans repayable to the United States without interest within ten years, for the cost of construction and equipment of health centers or clinics for diagnostic, preventive, or curative services, or of facilities for group practice, in order to encourage the establishment, modernization, or expansion of such centers, clinics or facilities in shortage areas, such grants or loans to be made to public or private organizations no part of the net earnings of which inures, or may lawfully inure, to the benefit of any private shareholder or individual, and which have not already received a construction grant under title VI of the Public Health Service Act;

(E) loans, repayable to the United States without interest within ten years, for the construction of health centers, clinics, and hospitals qualified to receive grants under title VI of the Public Health Service Act, as amended, except for inability to meet the financial assurances required under section 625 (a) of such Act: *Provided*, That the amount of any such loan shall not exceed the amount found by the National Health Insurance Board, with the advice of the Surgeon General, to be reasonably necessary for the construction of the facility, taking into account grants which may be made under title VI of the Public Health Service Act: *Provided further*, That loans for the full amount of the estimated cost of the facility may be made with the approval of the Surgeon General and the State agency designated pursuant to section 623 (a) of the Public Health Service Act, if all of the State's allotment has previously been committed through tentative approval of initial applications for other projects;

(2) Provision for mobile clinics, and for such ambulance service as is necessary to the effective utilization of hospital service in the area; and

(3) Provision for such special activities as may be appropriate in the particular area to acquaint eligible individuals in that area with the benefits available under title VII and the manner in which they may be obtained.

(b) Determinations that areas within a State are, or have ceased to be, shortage areas shall be made from time to time, with the approval of the National Health Insurance Board, by the State agency designated by the State plan approved under section 742 or, in the absence of such an approved plan for the State, by such Board after consultation with the health authority of the State, and such determinations, after the first surveys of personnel resources, facilities, and needs have been made pursuant to section 702 (a), shall take into account the results of such surveys.

RELATIONSHIP TO HOSPITAL CONSTRUCTION PROVISIONS

SEC. 403. (a) In establishing policies governing the making of grants and loans under subparagraph (1) (D) of section 402 (a) the National Health Insurance Board shall take into consideration the State construction programs and the policies and requirements (including the applicable limitation on the amount of Federal grants) contained in or established under title VI of the Public Health Service Act.

(b) If any person to whom a loan for the full amount of the cost of construction of a facility has been made under subparagraph (D) or (E) of section 402 (a) (1) subsequently applies under title VI of the Public Health Service Act for Federal aid in the construction of such facility, such application may be approved notwithstanding that it was filed after completion of construction of such facility, if it is otherwise in compliance with the requirements of section 625 of the Public Health Service Act. In any such case certification by the State agency of completion of the project in accordance with approved plans and specifications shall operate to reduce, by the amount of the Federal share, the sum which such person is obligated to repay to the United States on account of such loan and, if the amount of the Federal share exceeds the amount due on such loan, the balance of the Federal share shall be paid to such person.

ADMINISTRATION OF GRANTS FOR PROFESSIONAL EDUCATION

SEC. 404. In administering grants under the Public Health Service Act or title VI or VII of this Act for professional, technical, and administrative education and training, special consideration shall be given to the need for training or retraining of personnel who will practice, or are practicing, in shortage areas.

APPROPRIATIONS AUTHORIZED

SEC. 405. To carry out the purposes of this part and to assist in making the preparations necessary for making benefits available under title VII, there is hereby authorized to be appropriated for the fiscal year ending June 30, 1950, and for each of the three succeeding fiscal years, the sum of $35,000,000; and for each fiscal year thereafter such sum as may be necessary to carry out the purposes of this part.

PAYMENTS

SEC. 406. Grants or loans, under this title, in such amounts and for payment at such times as are approved by the National Health Insurance Board, shall be certified for payment to the Secretary of the Treasury, who shall pay them to the agency, institution, or individual designated by the Board to receive them.

ADMINISTRATION

SEC. 407. (a) Until the approval of a State plan under section 742, the National Health Insurance Board may carry out its functions under this part either directly or by making such working agreements as it may find feasible with any executive department or other agency of the United States, of the State, or of any political subdivision thereof, and, for the purpose of effectuating such working agreements, the Board may authorize appropriate transfers of funds and may delegate any of its powers and duties under this part except the making of regulations: *Provided*, That no commitment of aid under section 402 may be made in any State after approval of such State's plan under section 742 except through the State agency administering such plan.

(b) The National Health Insurance Board is authorized to make such regulations, after consultation with the National Advisory Medical Policy Council, as may be necessary to promote and facilitate the accomplishment of the objectives of this part, and it shall include in its annual reports to the Congress a full and detailed account of operations under this part and recommendations concerning such further legislative measures as it considers desirable to assure to people in shortage areas equitable opportunities to obtain the personal health service benefita available under title VII.

PART B—ASSISTANCE TO FARMERS' EXPERIMENTAL HEALTH COOPERATIVES

PURPOSES AND AUTHORIZATION OF APPROPRIATIONS

SEC. 421. The purpose of this part is to assist farmers' cooperatives in selected rural areas to initiate and carry out experimental plans for providing comprehensive medical care for their members, as a means of demonstrating the practicality and effectiveness of such plans. There is hereby authorized to be appropriated for the fiscal year ending June 30, 1950, the sum of $10,000,000, and for each of the four succeeding fiscal years the sum of $15,000,000, for carrying out such purpose through enabling the Surgeon General—

(a) to survey the practicality of the provision of medical care through farmers' cooperatives in selected rural areas and to make grants-in-aid to public and other nonprofit agencies and any other persons for such surveys and to render technical assistance in the organization and operation of such cooperatives;

(b) to make grants, as provided in this part, to such cooperatives to assist them in meeting the cost of providing comprehensive medical care, including the cost of providing facilities therefor.

COOPERATIVES ELIGIBLE

SEC. 422. Grants for the purposes specified in section 421 (b) shall be made to only such cooperatives as provide medical care in areas which surveys conducted pursuant to this part indicate such cooperatives may be practical. Such grants may be made to any cooperative—

(a) if substantially all of its members are residents of a rural area and not less than two-thirds of its members are farmers or agricultural workers or members of their families, except that the cooperative may also provide care for needy and other persons within the area served for whom the appropriate governmental units or other organizations have assumed responsibility;

(b) if regular payments from its members are required for purposes of financing the cost of providing the medical care and the maintenance and operation of the cooperative and are graduated in relation to income or income groups; and

(c) if it is authorized to furnish or arrange with qualified individuals and organizations to furnish medical care for its members and to take such other action as may be necessary to carry out the purposes of the cooperative under this part.

CONDITIONS FOR GRANTS

SEC. 423. To be eligible for a grant for any of the purposes specified in section 421, a cooperative must submit an application to the Surgeon General containing such information and assurances as he deems necessary to carry out the purposes of this part, including assurances that the cooperative will expend the funds paid to it under this part solely for the purposes for which they were paid and that it will make such reports, in such form and containing such informaiton, as the Surgeon General may from time to time require, and comply with such provisions as he may from time to time find necessary to assure the correctness and verification of such reports.

PAYMENT OF GRANTS

SEC. 424. (a) For each fiscal year the Surgeon General shall determine the total sum from the appropriation pursuant to section 421 which shall be available for grants for the purposes specified in paragraph (a) and for the purposes specified in paragraph (b) of such section. He shall from time to time determine the amounts to be paid from such sums under this part and shall certify such amounts to the Secretary of the Treasury together with the time or times of payment. The Secretary of the Treasury shall pay in accordance with such certifications and prior to audit or settlement by the General Accounting Office.

(b) No grant from funds appropriated pursuant to paragraph (b) of section 421 may exceed 50 per centum of the cost of providing medical care during the first or second year for which such a grant is made, or 33⅓ per centum of such cost during the third such year. In computing such cost, not more than 20 per centum thereof may be attibutable to the cost of acquisition or construction of facilities, land or equipment. No grant may be made under such paragraph for a second or third year to any cooperative for more than three years and no such grant may be made for a third year to any cooperative which provides medical care for less than five thousand individuals.

(c) The number of cooperatives receiving grants for the purposes specified in paragraph (b) of section 421 during any fiscal year may not exceed fifty nor may more than two cooperatives in any State receive such grants during any fiscal year.

ADMINISTRATION

SEC. 425. The Surgeon General shall carry out his functions under this part under the supervision and direction of the Federal Security Administrator. He shall, with the approval of the Federal Security Administrator and after consultation with the Secretary of Agriculture, prescribe such regulations as he deems necessary to carry out the purposes of this part. In carrying out his functions under this part, the Surgeon General is authorized, pursuant to agreement between the Federal Security Administrator and the head of any Federal agency, to utilize the services and facilities of such agency and to pay therefor either in advance or by way of reimbursement, as may be provided in such agreement.

WITHHOLDING

SEC. 426. Whenever the Surgeon General, after reasonable notice and opportunity to a cooperative receiving payments for the purposes specified in section 421 (b), finds that there is a failure to carry out any assurances required to be given in connection with such payments or a failure to comply with regulations under this part or with any other requirements of this part, he shall notify such cooperative that further payments will not be made to it for such purposes until he is satisfied that there no longer will be any such failure. Until he is so satisfied, he shall make no further certification to the Secretary of the Treasury for payment to such cooperative for such purposes.

DEFINITIONS

SEC. 427. For the purposes of this part—

(a) the term "medical care" means physicians' services, hospitalization, and laboratory and X-ray services, and may include dental care and such other related services as the cooperative desires;

(b) the term "State" includes Alaska, Hawaii, Puerto Rico, and the Virgin Islands;

(c) the term "rural area" means any area which is not, does not contain, and is not adjacent to any city or town having a population of ten thousand or more.

TITLE V—GRANTS TO STATES FOR STATE AND LOCAL HEALTH WORK

PURPOSE

SEC. 501. It shall be the national policy to assist the several States for the purpose of developing, extending, and improving—

(a) basic State and local public health organizations and the basic services provided thereby, in order that such services, together with all other services provided through such organizations, may be readily available in communities throughout each State;

(b) health services to the extent not otherwise available under title VII for the prevention, treatment, and control of disease, including services for the prevention, treatment, and control of mental illness, tuberculosis, venereal disease, cancer, heart disease, other chronic diseases, disorders associated with aging, dental disorders, nutritional-deficiency diseases, occupational and other diseases constituting special health problems, and services for the improvement of sanitation and other environmental factors affecting health;

(c) the training of personnel for State and local health work and methods for extending health services throughout each State.

GRANTS AND SERVICES TO STATES FOR PUBLIC HEALTH WORK

SEC. 502. (a) Section 315 of the Public Health Service Act is hereby repealed.

(b) Effective July 1, 1949, part B of title III of the Public Health Service Act is amended by repealing section 314 and inserting immediately following section 313 the act following new sections:

"APPROPRIATIONS FOR GRANTS AND SERVICES TO STATE

"SEC. 314. (a) There is hereby authorized to be appropriated for each fiscal year such amount as may be necessary for the purpose of—

(1) enabling the Surgeon General to assist the States and their political subdivisions, through grants, to develop and maintain adequate public health services, including establishment of local public health units necessary to make such services available throughout each State and including the training of personnel for State and local health work, and to provide adequate measures (not otherwise provided under title VII of the National Health Insurance and Public Health Act) for the prevention, treatment, and control of disease; and

(2) enabling the Surgeon General to provide demonstrations and to train personnel for State and local health work and to meet the cost of pay, allowances, and traveling expenses of commissioned personnel and other personnel of the Service detailed to assist States and their political subdivisions in carrying out the purposes of this subsection.

"(b) The amounts appropriated pursuant to subsection (a) of this section and determined to be available for allotment to States under section 315 shall be used for making payments to States which have submitted through the State health authority and have had approved by the Surgeon General plans for carrying out of the purposes of subsection (a).

"ALLOTMENT TO STATES

"SEC. 315. From the amounts appropriated pursuant to section 314 for each fiscal year, the Surgeon General, with the approval of the Administrator, shall determine the total sum which shall be available for allotment among the several States and shall, from time to time, in accordance with regulations and for specified periods, make allotments from such sum (including amounts allotted from such sum for any prior period in the same fiscal year and unpaid to the States) to the several States on the basis of (1) population, (2) per capita income as determined pursuant to subsection (d) of section 317, and (3) special factors relevant to the extent of the health problem in each such State. Upon making such allotments the Surgeon General shall notify the Secretary of the Treasury of the amounts thereof.

"APPROVAL OF STATE PLANS

"SEC. 316. (a) For any fiscal year the Surgeon General may by regulation prescribe, subject to any limitations specified in the appropriation made pursuant to section 314, the percentages of the allotments to the several States which may be withheld unless the State plan includes provisions (in addition to those required for the maintenance of the basic State health organizations and services) which meet the requirements of regulations, prescribed by the Surgeon General in order to effectuate the purposes of section 314 (a) for any of the following:

(1) the establishment, development, and maintenance of local public-health units and basic local health services;

(2) the prevention, treatment, and control of tuberculosis;

(3) the prevention, treatment, and control of venereal disease;

(4) the prevention, treatment, and control of cancer;

(5) the prevention, treatment, and control of mental illness;

(6) the prevention, treatment, and control of heart disease;

(7) the prevention, treatment, and control of other chronic diseases and disorders associated with aging;

(8) the prevention, treatment, and control of any other disease, or category of disease;

(9) the improvement of sanitation and other environmental factors affecting health;

(10) the extension of activities, or types of activity, in specific fields designated by the Surgeon General which have not generally been adequately developed as a part of public health services.

The percentages so reserved on account of the above items may be varied, in accordance with regulations, on the basis of the extent of the problem in the several States.

"(b) No State plan shall be approved unless it (1) provides such methods relating to the establishment and maintenance of personnel standards on a merit basis as the Surgeon General finds necessary to assure the proper and efficient administration of the plan (except that the Surgeon General shall exercise no authority with respect to the selection, tenure of office, or compensation of any individual employed in accordance with such methods), (2) provides that the State health authority will make such reports, in such form and containing such information, as the Surgeon General may from time to time require, and comply with such provisions as the Surgeon General may from time to time find necessary to assure the correctness and verification of such reports, and (3) provides that determination as to individuals to be furnished services under the plan shall be made without regard to economic status and on bases which do not discriminate between individuals on account of race, creed, color, or national origin, and which do not otherwise deny to any of them the equal protection of the laws.

"PAYMENTS TO STATES

"SEC. 317. (a) From the allotments available therefor under section 315 the Surgeon General shall from time to time certify to the Secretary of the Treasury for payment to each State which has an approved plan an amount, computed as provided in subsection (b) of this section, equal to the Federal share of the total expenditures under such plan by the State and its political subdivisions during the period for which such payment is to be made, except that in no case may the total amount certified for a fiscal year for a State exceed the amount of its allotment less any portion thereof withheld pursuant to subsection (a) of section 316. No expenditure from grants received from the Federal Government under any provision of law (other than pursuant to this section) and no expenditures made by political subdivisions from funds which have been received by it from the State and which have been reported as expenditures by that State shall be counted as a part of the total expenditures under the plan. The Secretary of the Treasury shall, prior to audit or settlement by the General Accounting Office, pay to each State the amount certified by the Surgeon General.

"(b) The Surgeon General shall, from time to time, but not less often than semiannually, and prior to the period for which a payment is to be made under subsection (a) estimate the amount, within the balance of the allotment for each State, which may be necessary to pay the Federal share of the total expenditures for carrying out the approved State plan for such period. The Surgeon General shall certify to the Secretary of the Treasury the amount so determined, reduced or increased, as the case may be, by the amount by which he finds that his estimate for any prior period was greater or less than the amount which should have been paid to the State for such period.

"(c) For the purposes of this section the 'Federal share' for any State shall be 100 per centum less the State percentage, and the State percentage shall be that percentage which bears the same ratio to 50 per centum as the per capita income of such State bears to the per capita income of the continental United States, except that (1) the Federal share shall in no case be more than 75 per centum or less than 40 per centum, and (2) the Federal share for Alaska and Hawaii shall be 50 per centum and for Puerto Rico and the Virgin Islands shall be 75 per centum.

"(d) The 'Federal share' for each State shall be promulgated by the Administrator between July 1 and August 31 of each even-numbered year, on the basis of the average of the per capita incomes of the States and of the continental United States (excluding Alaska) for the three most recent consecutive years for which satisfactory data are available from the Department of Commerce. Such promulgation shall be conclusive for each of the two fiscal years in the period beginning July 1 next succeeding such promulgation: *Provided*, That the Administrator shall make such promulgation as soon as possible after the enactment of this Act to be effective until July 1, 1951.

"OPERATION OF STATE PLANS

"SEC. 318. Whenever the Surgeon General, after reasonable notice and opportunity for hearing to the State health authority, finds that there is a failure to comply substantially with—

(1) the provisions of section 316 of this Act;
(2) the approved State plan; or
(3) the regulations of the Surgeon General;

the Surgeon General shall notify the State health authority that further payments will not be made to the State from appropriations under section 314 (or, in his discretion, that further payments will not be made to the State from such appropriations for activities in which there is such failure) until he is satisfied that there will no longer be any such failure. Until he is so satisfied, the Surgeon General shall make no further certification for payment to such State, or shall limit payment to activities in which there is no such failure.

"REGULATION

"SEC. 319. All regulations and amendments thereto with respect to grants to States under this part shall be made after consultation with a conference of the State health authorities (including the State mental health authorities). Insofar as practicable, the Surgeon General shall obtain the agreement, prior to the issuance of any such regulations or amendments, of the State health authorities (including the State mental authorities)."

USE OF EXISTING APPROPRIATIONS

SEC. 503. Any amounts appropriated for the fiscal year ending June 30, 1950, for any of the purposes included in section 314 of the Public Health Service Act, as amended by this Act, shall be available for carrying out such purposes in accordance with the provisions of such section as so amended: *Provided*, That the Surgeon General may designate the extent to which regulations promulgated pursuant to section 314 of the Public Health Service Act, prior to its amendment by this Act, shall govern allotments and payments to States for such fiscal year.

VITAL STATISTICS

SEC. 504. Section 313 of the Public Health Service Act is hereby amended to read as follows:

"PUBLIC EDUCATION, INFORMATION, AND VITAL STATISTICS

"SEC. 313. (a) From time to time the Surgeon General shall issue information related to public health, in the form of publications or otherwise, for the use of the public, and shall publish weekly reports of health conditions in the United States and other countries and other pertinent health information for the use of persons and institutions engaged in work related to the functions of the service.

"(b) To secure uniformity in the registration of mortality, morbidity, and other vital statistics, the Surgeon General shall prepare and distribute suitable and necessary forms for the collection and compilation of such statistics which shall be published as a part of the health reports published by the Surgeon General."

TITLE VI—RESEARCH IN CHILD LIFE AND GRANTS TO STATES FOR MATERNAL AND CHILD HEALTH AND CRIPPLED CHILDREN'S SERVICES

PART A—RESEARCH IN CHILD LIFE

AUTHORIZATION OF APPROPRIATION

SEC. 601. In order to carry out more effectively the purposes of investigating and reporting upon all matters pertaining to the welfare of children and child life as provided for in the Act of April 9, 1912 (37 Stat. 79), there is hereby authorized to be appropriated for the fiscal year ending June 30, 1950, the sum of $10,000,000, and for each fiscal year thereafter such sums as may be necessary to enable the Federal Security Administrator (hereafter in this title called the "Administrator"), through the Children's Bureau, to conduct and foster research in child life as provided in such Act of April 9, 1912, and in consultation with the National Advisory Council on Research in Child Life (hereafter in this title called the "Advisory Council"), to—

(a) (1) make grants-in-aid to universities, child research institutes, and other public or nonprofit agencies and institutions, and to individuals, for research projects relating to the development of children and community aspects of child life (hereafter in this title referred to as child life and development) after consultation with the Advisory Council, including grants for the construction, acquisition, leasing, equipment, and maintenance of facilities and services necessary for such research; and (2) establish and maintain research fellowships in child life and development in universities, research centers and other public or nonprofit agencies and institutions and in the Children's Bureau with such stipends and allowances (including travel and subsistence expenses) as he may deem necessary to train research workers and procure the assistance of the most able and promising research fellows from the United States and abroad, and, in addition, provide for such fellowships through grants, after consultation with the Advisory Council, to public and other nonprofit institutions;

(b) extend and improve training and instruction in child life and development through grants to universities, child research centers, and other public or nonprofit agencies and institutions, and establish and maintain traineeships in child life and development in the Children's Bureau or through grants to such agencies and institutions, with such stipends (including travel and subsistence expenses) for trainees as he may deem necessary;

(c) adopt, after consultation with the Advisory Council, such additional means or measures as he deems necessary or appropriate to carry out the purposes of this title.

CONTRACTUAL AUTHORITY

SEC. 602. A grant for any research or training project made in any fiscal year under section 601 may include amounts for not to exceed the four succeeding fiscal years and such amounts for such succeeding fiscal years (which may not for all such projects exceed a total of $16,000,000 for any such year) shall constitute contractual obligations of the Federal Government.

NATIONAL ADVISORY COUNCIL ON RESEARCH IN CHILD LIFE

SEC. 603. There is hereby established a National Advisory Council on Research in Child Life to advise and make recommendations to the Administrator and the Children's Bureau on grants for research and training provided for in section 601. The Advisory Council shall consist of the Chief of the Children's Bureau, the Surgeon General of the Public Health Service, the Commissioner of Education, or such persons as they may designate, ex officio, and twelve members appointed without regard to the civil-service laws by the Administraor. The twelve appointed members shall be selected from among leaders in the fields of the social and biological sciences, education, and public affairs, including persons generally representative of the public, and six of the twelve shall be selected from leading scientific authorities who are outstanding in the study of child life and development. One-third of the members first appointed shall serve for terms of one year, one-third for two years, and one-third for three years, as designated by the Administrator at the time of appointment, and at the expiration of such terms their successors shall be appointed for terms of three years. The Advisory Council shall annually elect one of its members as chairman.

COORDINATION OF ACTIVITIES

SEC. 604. Research activities and investigations provided for in this part shall be coordinated with related activities planned or undertaken by other units of the Federal Security Agency and by other Government agencies.

EXISTING AUTHORITIES PRESERVED

SEC. 605. This part shall not be construed as superseding, curtailing, or limiting (1) the authorities or functions under any other provision of this Act, or under any other Act, of the Administrator, the Children's Bureau, or any other officer or agency of the United States, relating to the study of child life and development; or (2) the expenditure of money therefor.

PART B—GRANTS TO STATES

PURPOSES

SEC. 611. Moneys appropriated under this part shall be available for the purposes of—

(a) enabling each State to extend and improve, as far as practicable under the conditions in such State, especially in rural areas, the following services and facilities (including training of persons to furnish such services), to the extent that such services and facilities are not otherwise available under this Act or the amendment made by this Act:

(1) services and facilities for promoting the physical and mental health of mothers during maternity, of infants, and of children under 18 years of age, including medical, dental, hospital, and related services and facilities, and particularly the correction of defects and health conditions in children of pre-school and school age likely to interfere with their normal development and educational progress;

(2) services and facilities for locating crippled or otherwise physically handicapped children under twenty-one years of age or children under such age who are suffering from conditions which lead to crippling or physical handicap, and for providing medical, surgical, corrective, dental, and other services and care, including diagnosis, treatment, hospitalization, after care, appliances, and whatever health services and facilities are needed for such children;

(b) enabling the Federal Security Administrator (1) to promote and develop more effective measures for carrying out the purposes of this title, either directly or through grants, through (A) demonstrations, (B) studies of the effectiveness of the administration and the operation of the programs, and (C) training for the administration and the provision of maternal and child health and crippled children's services to be furnished under this title, including stipends, and travel and subsistence expenses for trainees; (2) to pay salaries and expenses of personnel detailed by the Federal Security Administrator at the request of State agencies or training institutions to cooperate on a temporary basis with and assist such agencies or institutions in carrying out the purposes of this title; (3) to cooperate with States in reviewing and planning for the needs of children; and (4) to meet all necessary expenses of the Federal Security Agency in administering the provisions of this title.

AUTHORIZATION OF APPROPRIATIONS

SEC. 612. (a) There are hereby authorized to be appropriated for the fiscal year ending June 30, 1950, the sums of $25,000,000 for maternal and child health services pursuant to the purposes of subsection (a) (1) and subsection (b) of section 611, and $25,000,000 for crippled children's services pursuant to the purposes of subsection (a) (2) and subsection (b) of section 611, and for each fiscal year thereafter a sum sufficient to carry out the purposes of subsections (a) and (b). Not more than 10 per centum of the amounts so appropriated shall be available for the purposes of subsection (b) of section 611.

(b) The sums authorized pursuant to subsection (a) and determined to be available for allotment to the States under section 613 shall be used for making payments to States which have submitted to and had approved by the Administrator plans for developing programs for maternal and child health or crippled children's services.

ALLOTMENTS TO STATES

SEC. 613. (a) Out of the sums appropriated pursuant to section 612 (a) for each fiscal year, the Administrator shall determine the sums which shall be available for allotment among the several States for the purposes set forth in clauses (1) and (2), respectively, of section 611 (a), and the sums which shall be available for the purposes set forth under section 611 (b).

(b) The Administrator shall from time to time make allotments from such sums determined to be available for the purposes set forth in section 611 (a) (including amounts allotted therefrom for any prior period in the same fiscal year and unpaid to the States) to the several States on the basis of (1) the number of children in each State according to the most recent census estimates, (2) per capita income as determined pursuant to section 615, and (3) special factors relevant to the extent of the particular child-health problem or problems in the respective States. Upon making such allotments, the Administrator shall notify the Secretary of the Treasury and each State of the amounts thereof.

APPROVAL OF STATE PLANS

SEC. 614. (a) Each State plan for maternal and child health services and for crippled children's services must (1) provide for substantial financial participation by the State; (2) provide for administration or supervision of the administration of the maternal and child health plan by the State health agency; and for administration or supervision of the administration of the crippled children's plan by a single State agency, which, not later than the end of the fifth year after the date of enactment of this Act, shall be the same State health agency which administers or supervises the administration of the maternal and child health services provided for under this title; (3) provide such methods of administration as are necessary for the proper and efficient operation of the plan, including methods relating to the establishment and maintenance of (A) personnel standards on a merit basis, except that the Administrator shall exercise no authority with respect to the selection, tenure of office, or compensation of any individual employed in accordance with such methods, and (B) State standards for care and services to be furnished to individuals under the plan, including standards for professional personnel rendering medical, dental, social, nursing, and related types of care or services, and standards for care and services in hospitals and other institutional care and services; (4) provide that the State agency will make such reports, in such form and containing such information, as the Administrator may find necessary, and comply with such provisions as the Administrator may from time to time find necessary to assure the correctness and vertification of such reports; (5) provide for carrying out the purposes of section 611 (a) (1) or (2), as the case may be, and for the progressive development of State-wide programs for maternal and child health and crippled children's services with emphasis at the beginning on areas of greater need and for extension and improvement of services each year at a rate consistent with availability of personnel and facilities meeting standards established under the State plans; (6) provide that determinations as to the children to be furnished services under the plan shall be made without regard to economic status and on bases which do not discriminate between children on account of race, creed, color, or national origin, and which do not otherwise deny to any of them the equal protection of the laws; (7) provide for safeguards which restrict the use or disclosure of information concerning persons receiving service or care to purposes directly connected with the operation of the State plan; (8) provide for cooperation with other appropriate agencies and organizations in the health, welfare, education, and related fields, including, where necessary, entering into working agreements with other public agencies administering or providing services related to those furnished under the plan; (9) provide for study and evaluation of the effectiveness of the programs in meeting the needs of mothers and children throughout the States; and (10) provide for the designation of an advisory council or councils and for technical advisory committees, as may be necessary for carrying out the purposes of this title, to consult with the State agency in carrying out the plan, such councils and committees to be composed of representatives of public and private agencies or organizations administering related programs, of persons chosen from the professions whose members furnish services under the plan, and, in the case of the councils, of representatives of the public selected from persons who are informed on the need for services provided under the plan.

(b) The Administrator shall approve any plan or plans which fulfill the conditions specified in subsection (a) of this section and shall thereupon notify the State agency or agencies of his approval.

PAYMENTS TO STATES

SEC. 615. (a) From the allotments available therefor under section 613, the Secretary of the Treasury shall from time to time pay to each State which has an approved plan or plans for carrying out the purposes set forth in section 611 (a) (1) or (2), as the case may be, amounts, computed as provided in subsection (b) of this section, equal to the Federal share of the total sums expended by the State or its political subdivisions under the State plans during the period for which such payment is made. No expenditure from grants received from the Federal Government under any provision of law (other than pursuant to this section) and no expenditures made by political subdivisions from funds which have been received by it from the State and which have been reported as expenditures by the State shall be counted as a part of the total expenditures under the plan. The Secretary of the Treasury shall, prior to audit or settlement by the General Accounting Office, pay to each State the amount certified by the Administrator.

(b) The Administrator shall, from time to time, but not less often than semiannually and prior to the period for which a payment is to be made under subsection (a), estimate the amount, within the balance of the allotments for each State, which may be necessary to pay the Federal share of the total expenditures for carrying out the approved State plan or plans for such period. The Administrator shall certify to the Secretary of the Treasury the amount so determined, reduced, or increased, as the case may be, by the amount by which he finds that his estimate for any prior period was greater or less than the amount which should have been paid to the State for such period.

(c) For the purposes of this section, the "Federal share" for any State shall be 100 per centum less the State percentage, and the State percentage shall be that percentage which bears the same ratio to 50 per centum as the per capita income of such State bears to the per capita income of the continental United States, except that (1) the Federal share shall in no case be more than 75 per centum or less than 40 per centum, and (2) the Federal share for Alaska and Hawaii shall be 50 per centum and for Puerto Rico and the Virgin Islands shall be 75 per centum.

(d) The "Federal share" for each State shall be promulgated by the Administrator between July 1 and August 31 of each even-numbered year, on the basis of the average of the per capita incomes of the States and of the continental United States (excluding Alaska) for the three most recent consecutive years for which satisfactory data are available from the Department of Commerce. Such promulgation shall be conclusive for each of the two fiscal years in the period beginning July 1 next succeeding such promulgation: *Provided*, That the Administrator shall make such promulgation as soon as possible after the enactment of this Act to be effective until July 1, 1951.

OPERATION OF STATE PLANS

SEC. 616. Whenever the Administrator, after reasonable notice and opportunity for hearing to the State agency administering or supervising the administration of a State plan, finds that, with respect to any plan for carrying out the purposes of clause (1) or (2) of section 611 (a), as the case may be, there is a failure to comply substantially with the provisions required by section 614 to be included in such plan or that the State plan has been so changed that it no longer complies with such provisions, he shall notify such State agency that further payments will not be made to the State from appropriations available for the purposes of such clause, or in his discretion that further payments will not be made to the State from such appropriations for activities in which there is such failure, until he is satisfied that there will no longer be any such failure. Until he is so satisfied, the Adminstrator shall make no further certification for payment to such State from appropriations available for the purposes of such clause, or shall limit payment to activities in which there is no such failure.

ADMINISTRATION

SEC. 617. The Administrator shall perform the functions with which he is charged under this part through the Children's Bureau and such other units of the Federal Security Agency as he may determine, and he may delegate such functions to officers and employees of the Agency.

PART C—MISCELLANEOUS

REGULATIONS

SEC. 621. The Administrator shall prescribe such regulations as may be necessary to carry out his functions under this title. Regulations and amendments thereto with respect to State plans under this title, and grants on the basis hereof, shall be made after consultation with representatives of the State agencies administerting or supervising the administration of any of the plans concerned. Insofar as practicable, the agreement of such representatives to the regulations or amendments shall be obtained prior to their issuance.

ADVISORY COMMITTEES

SEC. 622. The Administrator is authorized to appoint such special advisory and technical committees as may be useful in carrying out his functions under this title or the functions of the Advisory Council established by section 603, and members of the Advisory Council and of such advisory and technical committees, other than ex officio members, while attending conferences or meetings of the Council or their committees or while otherwise serving at the request of the Administrator shall be entitled to receive compensation at a rate to be fixed by the Administrator, but not exceeding $50 per diem, and shall also be entitled to receive an allowance for actual and necessary travel and subsistence expenses while so serving away from their places of residence.

ANNUAL REPORT

SEC. 623. The Administrator shall include in his annual report to the Congress a full account of the administration of this title including a record of consultations with the Advisory Council and advisory or technical committees and with conferences of representatives of State agencies administering or supervising the administration of plans approved under part B of this title.

DEFINITION OF STATE

SEC. 624. For purposes of this title the term "State" means a State, or the District of Columbia, Hawaii, Alaska, Puerto Rico, or the Virgin Islands.

EXISTING LAWS AND APPROPRIATIONS

SEC. 625. (a) No payment shall be made to a State under part 1 or 2 or title V of the Social Security Act for any period for which payments are made to such State for the purposes of clauses (1) and (2), respectively, of section 602 (a) or for any period thereafter. In no event may any payment be made to a State under part 1 or 2 of Title V of such Act for any period after June 30, 1951.

(b) In the case of a State which has a plan approved under part B of this title, adjustments, which have not previously been made with respect to overpayments or underpayments under part 1 or 2 of title V of the Social Security Act, shall be made in connection with payments to such State under part B of this title.

(c) Appropriations to carry out the purposes of part 1 or 2 of title V of the Social Security Act for the fiscal year ending June 30, 1950, shall also be available for payments for such fiscal year for the purposes of clauses (1) and (2), respectively, of section 611 (a) of this Act.

TITLE VII—PREPAID PERSONAL HEALTH INSURANCE BENEFITS

PART A—FINDINGS AND DECLARATIONS

SEC. 700. The Congress hereby declares that it is the policy of the United States to take such steps and to utilize such of its resources as are necessary toward making adequate health services available to all our people regardless of residence, race, creed, color or economic status.

PART B—BENEFITS AND ELIGIBILITY

CLASSES OF PERSONAL HEALTH SERVICES

SEC. 701. (a) The personal health services to be made available as benefits to eligible individuals as provided in this part are medical services, dental services, home-nursing services, hospital services, and auxiliary serves. Each class of servces shall be provided by persons (including individuals, partnerships, corporations, associations, consumer cooperatives, and other organizations) who are authorized by applicable State law, and who are qualified under part C of this title, to do so.

(b) Medical services consist of (1) general medical services such as can be rendered by a physician engaged in the general or family practice of medicine, including preventive, diagnostic, and therapeutic care and periodic medical examinations; and (2) specialist services rendered by a physician who is a specialist in the class of services rendered, as defined in section 711 of this Act. Such services may be rendered at the office, home, hospital, or elsewhere, as necessary.

(c) Dental services consist of (1) general dental services rendered by a dentist engaged in the general practice of denistry, including preventive, diagnostic, and therapeutic care, and periodic dental examinations; and (2) specialist services rendered by a dentist who is a specialist in the class of services rendered, as defined in section 711 of this Act. Such services may be rendered at the office, home, hospital, or elsewhere, as necessary.

(d) Home-nursing services consist of nursing care of the sick rendered in the home by a registered professional nurse or a qualified practical nurse.

(e) Hospital services consist of hospitalization, including necessary nursing services, and such physician, laboratory, ambulance, and other services in connection with hospitalization as the National Health Insurance Board (hereinafter referred to as the "Board"), after consultation with the National Advisory Medical Policy Council (hereinafter referred to as the "Advisory Council"), by regulation designates as essential to good hospital care, for a maximum of sixty days in any benefit year; but hospital services shall not include hospitalization in a mental or nervous disease or tuberculosis hospital or institution, or hospitalization for any day more than thirty days following the diagnosis of tuberculosis or a psychosis. Whenever the Board, after consultation with the Advisory Council, finds that moneys in the account (established by section 771) are adequate and that facilities are available, it may by regulation increase the maximum days of hospitalization in any benefit year.

(f) Auxiliary services consist of such chemical, bacteriological, pathological, diagnostic X-ray and related laboratory services; X-ray, radium, and related therapy; physiotherapy; services of optometrists and chiropodists; and prescribed drugs which are unusually expensive, special appliances, and eyeglasses; as the Board, after consultation with the Advisory Council, by regulation designates as auxiliary services on the basis of its finding that their provision under this title is practicable and is essential to good health care.

AVAILABILITY OF BENEFITS

SEC. 702. (a) Medical services, hospital services, and, except as otherwise provided in subsection (b) of this section, all other personal health services specified in section 701 shall be made available as benefits to eligible individuals in all health-service areas within the United States as rapidly and as completely as possible having regard for the availability of the professional and technical personnel and the hospital and other facilities needed to provide such services. To this end the resources and needs of each State shall be surveyed and a program developed in each State to assure the maximum participation and use of health personnel and facilities in the provision of benefits, and to encourage improvement in the number and distribution of such personnel and facilities throughout the State. Additional surveys shall be undertaken as required, and the program in the State from time to time modified on the basis thereof.

(b) If the Board, after consultation with the Advisory Council, finds that the personnel or facilities or funds that are or can be made available are inadequate to insure the provision of all services included as dental, home-nursing, or auxiliary services under section 701 of this title, it may by regulation limit for a specified period the services which may be provided as benefits, or modify the extent to which, or the circumstances under which, they will be provided to eligible individuals. Any such restriction or limitation shall be reduced or withdrawn as rapidly as may be practicable; and, in the case of dental services, priority in the reduction or withdrawal of any such restriction or limitation shall be given to children.

(c) The Board shall have the duty of studying and making recommendations as to needed services and facilities for the care of the chronic sick afflicted with physical ailments, and for the care of individuals aflicted with mental or nervous diseases, and as to needed provisions for the prevention of chronic physical diseases and of mental or nervous diseases; and of making reports from time to time, with recommendations as to legislation, but the first such report shall be made not later than two years after benefits under this title first become available.

HOW BENEFITS OBTAINED; FREE CHOICE BY PATIENT

Sec. 703. Every individual eligible for personal health services available under this title may freely select the physician, dentist, nurse, medical group, hospital, or other person of his choice to render such services, and may change such selection: *Provided*, That the practitioner, medical group, hospital, or other person has agreed under part C to furnish the class of services required and consents to furnish such services to the individual. General medical and general dental services may be obtained by request made by the individual directly to the practitioner of the individual's choice. Specialist, home-nursing, hospital, and auxiliary services shall be obtained from the specialist, nurse, hospital, or other person of the individual's choice, whenever the practitioner from whom he is receiving medical or dental services as benefits under this title refers him for specialist, home-nursing, hospital, or auxiliary services upon determining that such services are required in the proper care of his particular case; or whenever, upon request of the individual, an administrative medical officer, upon a like determination, refers him for such services. The Board, by regulation, shall dispense with the necessity of referral in cases of emergency, and may dispense with the necessity of referral under specified circumstances or as respects specified classes of services, or both, if it finds, after consultation with the Advisory Council, that such action will be conducive to the provision of more adequate amount and quality of health care and will not unreasonably increase the expenditures from the account for such services.

ELIGIBILITY FOR BENEFITS

Sec. 704. (a) Every individual shall be eligible for benefits under this title throughout any benefit year if—

(1) he has recevied (or, in the case of income from self-employment, has accrued)—

(A) not less than $150 in wages during the first four of the last six calendar quarters preceding the beginning of the benefit year; or

(B) not less than $50 in wages in each of six calendar quarters during the first twelve of the last fourteen calendar quarters preceding the beginning of the benefit year (not counting as one of such fourteen calendar quarters any quarter in any part of which the individual was under a total disability which continued for six months or more);

(2) he is entitled, for the first month in the benefit year, to a benefit under title II of the Social Security Act, as amended, or to an annuity under the Civil Service Retirement Act, as amended (5 U. S. C., ch. 14); or

(3) he is on the first day of the benefit year a dependent of an individual who is eligible under paragraph (1) or paragraph (2).

(b) Every individual, not eligible therefor under subsection (a), shall be eligible for benefits under this title during the remainder of a benefit year, beginning with—

(1) the first day of any calendar quarter in such benefit year, if he has received (or, in the case of income from self-employment, has accrued) not less than $150 in wages during the first four of the last six calendar quarters preceding the beginning of such calendar quarter;

(2) the first day of the first month in such benefit year for which he is entitled to a benefit or annuity referred to in subsection (a) (2); or

(3) the first day in such benefit year on which he is or becomes a dependent of an individual who is eligible for benefits under subsection (a) (1) or (2) or under paragraph (1) or (2) of this subsection.

(c) No individual shall be deemed eligible for any personal health services as a benefit under this title which are required by reason of any injury, disease, or disability on account of which any medical, dental, home-nursing, hospital, or auxiliary service is being received, or upon application therefor would be received, under a workmen's compensation law of the United States or of any State, unless equitable reimbursements to the account for the provision of such services as benefits have been made or assured under section 705 of this title. In any case in which an individual receives any personal-health service as a benefit under this title with respect to any such injury, disease, or disability, for which no reimbursement to the account has been made or assured, the United States shall to the extent permitted by State law be subrogated to all rights of such individual, or of the person who furnished such service, to be paid or reimbursed, pursuant to such workmen's compensation law, for the cost of furnishing such service.

PROVISION OF BENEFITS FOR NONINSURED NEEDY AND OTHER INDIVIDUALS

SEC. 705. (a) Any or all benefits provided under this title to individuals eligible for such benefits may be furnished to individuals (including the needy) not otherwise eligible therefor, for any period for which equitable reimbursements to the account on behalf of such needy or other individuals have been made, or for which reasonable assurance of such reimbursements has been given, by public agencies of the United States, the several States, or any of them or of their political subdivisions, such reimbursements to be in accordance with agreements and working arrangements negotiated with such public agencies. Services furnished to such needy or other individuals as benefits shall be of the same quality, be furnished by the same methods, and be paid for through the same arrangements, as services furnished to individuals eligible for benefits under this title.

(b) Federal grants to States under title I, IV, and X of the Social Security Act, as amended, shall be available to the States for provision of personal-health services for noninsured needy individuals in accordance with the provisions of subsection (a) of this section and of section 782.

PART C.—PARTICIPATION OF PHYSICIANS, DENTISTS, NURSES, HOSPITALS, AND OTHERS

PHYSICIANS AND DENTISTS; SPECIALISTS

SEC. 711. Any individual who is a physician or a dentist legally authorized in a State to render any services included as general medical services or general dental services shall be deemed qualified to render such services in that State as benefits under this title. Any such individual who is found to possess skill and experience of a degree and kind sufficient to meet standards established for a class of specialist services shall be deemed qualified to receive compensation for specialist services of such class as benefits under this title. The Board, after consultation with the Advisory Council, shall establish standards as to the special skills and experience required to qualify an individual to render each such class of specialist services as benefits under this title, and to receive compensation for such specialist services. In establishing such standards and in determining whether individuals qualify thereunder, standards and certifications developed by professional agencies shall be utilized as far as is consistent with the purposes of this title, and regard shall be had for the varying needs and the available resources in professional personnel of the States and of local health-service areas.

NURSES

SEC. 712. Any individual shall be deemed qualified to render home-nursing services in a State as benefits under this title if such individual is (a) a professional nurse registered in such State, or (b) a practical nurse (1) who is qualified as such under State standards or requirements, or, in the absence of State standards or requirements, is found to be qualified under standards established by the Board after consultation with the Advisory Council and with nursing agencies, and (2) who furnishes nursing care under the direction or supervision of the State health agency, the health agency of a political subdivision of the State, or an organization supplying and supervising the services of registered professional nurses in the State.

HOSPITALS

SEC. 713. Any hospital or other institution shall be deemed qualified to furnish all or particular classes of hospital services as benefits under this title if it is qualified to furnish such services under State standards or requirements for the maintenance and operation of hospitals which apply to the class or classes of services to be furnished, or if, in the absence of such State standards or requirements, it is found to afford professional services, personnel, and equipment adequate to promote the health and safety of individuals requiring the class or classes of hospital services to be furnished, according to standards which the Board shall establish after consultation with the Advisory Council.

AUXILIARY SERVICES

SEC. 714. Any person (as defined in section 781 (1)) who is qualified under State standards or requirements to furnish a class of services included as auxiliary services, or, in the absence of State standards or requirements, is found to be qualified to furnish a class of such services under standards established for such class by the Board after consultation with the Advisory Council, shall be deemed qualified to furnish such class of auxiliary services in that State as benefits under this title.

AGREEMENTS WITH INDIVIDUAL PRACTITIONERS, HOSPITALS, AND OTHERS

SEC. 715. Any individual (or, in the case of hospital or auxiliary services, any person) qualified under this part to furnish any class or classes of personal health services as benefits may enter into an agreement with the State agency which in accordance with part E has assumed responsibility for the administration in the State of benefits under this title (hereinafter in this title referred to as the "State agency"), to furnish such class or classes of services as benefits to individuals eligible therefor under this title.

AGREEMENTS WITH VOLUNTARY HEALTH INSURANCE AND OTHER ORGANIZATIONS

SEC. 716. (a) In the provision of personal health services, it shall be the policy to utilize individuals or organizations qualified under this part to render such services, including (1) any organized group of individuals, (2) any partnership, association, or consumer cooperative, (3) any hospital or any hospital and its staff, or (4) any organization operating a voluntary health-service insurance plan or other voluntary health-service plan.

(b) The State agency is authorized to enter into an agreement with any organization referred to in subsection (a) for the provision of personal health services under this title. Any such organization, whether or not it enters into an agreement with the State agency on its own behalf, shall be permitted to act as agent for individuals or other persons in negotiating or in carrying out agreements with the State agency for rendering personal health services under this title.

(c) Any agreement under this section shall provide that each class of personal health services will be furnished only by individuals (or, in the case of hospital or auxiliary benefits, by persons, as defined in section 781 (1)) who are qualified under this part to render such class of services, and each of whom has agreed or has authorized an agreement to be made on his behalf with the State agency that he will furnish such services in accordance with this title and with regulations prescribed thereunder. Each such individual or person shall be responsible, both to the State agency and (in accordance with applicable State law) to individuals eligible for personal health services as benefits, for carrying out such agreement made by him or on his behalf.

PROVISIONS COMMON TO ALL AGREEMENTS

SEC. 717 (a) Each agreement made under this part shall specify the class or classes of services to be furnished or provided pursuant to its terms, shall contain an undertaking to comply with this title and with regulations prescribed thereunder, shall be made upon terms and conditions consistent with the efficient and economical administration of this title, and shall continue in force for such period and be terminable upon such notice as may be agreed upon.

(b) No agreement under section 716, and no designation of an agent, shall for more than one year preclude any individual or person qualified to furnish personal health services from exercising such rights as he would otherwise have under this part (1) to negotiate and enter into an agreement directly with the State agency, or (2) to designate another agent for such negotiation, or (3) to participate in another agreement under section 716.

(c) No agreement made under this part shall confer upon any individual or other person, or any group or other organization, the right of furnishing or providing personal health services as benefits, to the exclusion in whole or in part of other individuals, persons, groups, or organizations qualified to furnish or provide such services.

(d) If the State agency after investigation finds that an individual or other person under agreement to furnish or provide personal health services as benefits is no longer qualified to furnish or provide such services, or has committed a substantial breach of the agreement, it shall notify such person of its findings, together with the reasons therefor, and in the absence of a request for a hearing by such person under part G, or in the event of a final decision sustaining its findings after any hearing and further review provided under part G, may terminate the agreement and withdraw the person's name from the lists published pursuant to part D. After an agreement has been so terminated, no new agreement shall be entered into with such person under this title unless and until such person gives reasonable assurances to the State agency of his or its ability and willingness to discharge all obligations and responsibilities under a new agreement satisfactorily in accordance with its provisions.

METHODS OF PAYMENTS FOR SERVICES

SEC. 718. (a) Agreements for the furnishing of medical or dental services (other than specialist services) as benefits under this title shall provide for payment—

(1) on the basis of fees for services rendered as benefits, according to a fee schedule;

(2) on a per capita basis, the amount being according to the number of individuals eligible for benefits who are on the practitioner's list;

(3) on a salary basis, whole time or part time; or

(4) on such combinations or modifications of these bases, including separate provision for travel and related expenses, as may be approved by the State agency;

according in each health-service area as the majority of the medical practitioners or of the dental practitioners, respectively, under agreement to furnish such services shall elect: *Provided*, That provision shall be made for another method or methods of payment (from among the methods listed in this subsection) to those medical practitioners or to those dental practitioners who do not elect the method of such majority, when it is found that such alternative method of making payments contributes to carrying out the provisions of section 735 of this title or otherwise promotes the efficient and economical provision of medical or dental services in the area.

(b) Agreements for the furnishing of specialist services as benefits under this title may provide for payments on the basis of fee for service, per case, per session, per capita, on salary (whole time or part time), or other basis, or combination thereof.

(c) Any of the methods of making payments from among the methods listed in subsection (a) or subsection (b) may be used in making payments to groups of practitioners or organizations or other agencies which undertake to provide specialist services as well as general medical or general dental services.

(d) Agreements for the furnishing of hospital services as benefits under this title shall provide for payment on the basis of the reasonable costs of hospitalization furnished as benefits: *Provided*, That the Board, after consultation with the Advisory Council and with representatives of interested hospital organizations, may by regulation prescribe maximum rates for hospitalization furnished as benefits under this title, and such maximum rates may be varied according to classes of localities or types of service. Payments to hospitals shall be based on the least expensive multiple-bed accommodations available in the hospital unless the patient's condition makes the use of private accommodations essential for his proper medical care. An agreement made for furnishing such services shall not affect the right of the hospital or other person with whom the agreement is made to require payments from patients with respect to the additional cost of more expensive facilities occupied at the request of the patient, or with respect to services not included as benefits under this title.

(e) Agreements for the furnishing of home-nursing services or auxiliary services as benefits under this title shall provide for payment in accordance with such methods as the State agency may approve from among those set forth in regulations prescribed pursuant to this title.

(f) In any health-service area where agreements for the furnishing of general medical or general dental services provide for payment only on a per capita basis, the per capita payments with respect to those individuals residing in the area who have failed to select a practitioner or other person to furnish such services to them shall be made on a pro rata basis among the practitioners and other persons under agreement to furnish such services in the area.

AMOUNT OF PAYMENTS FOR SERVICES

SEC. 719. (a) Rates or amounts of payment for particular services or classes of services furnished as benefits under this title shall be adapted to take account of relevant regional, State, or local conditions and practices. In arriving at the payments to be made for services of general medical and dental practitioners, specialists, professional and practical nurses, or other practitioners, regard shall be had for the annual income or its equivalent which the payments will provide, and consideration shall be given to degree of specialization, and to the skill, experience, and responsibility involved in rendering the services. Such payments, together with the other terms and conditions of the agreements made under this part, shall be adequate to provide professional and financial incentives to practitioners to advance in their professions and to practice in localities where their services are most needed, to encourage high standards in the quality of services furnished, to give assistance in their use of opportunties for postgraduate study, and to allow for adequate vacation.

(b) The rates and amounts of payments fixed under the different methods of payments specified in subsections (a), (b), (c), and (e) of section 718, and the methods of making payments, shall assure reasonably equivalent awards for practitioners selecting different methods of payment, in consideration of the value of the services they render.

(c) Maximum limits upon the number of eligible individuals with respect to whom any person may undertake to render services in any local health-service area may be fixed by the local administrative committee or local administrative officer of that health-service area only on the basis of a recommendation of the professional committee in that area that such limitation is necessary to maintain high standards in the quality of medical, dental, or other services furnished as benefits. Any such limits shall take account of professional needs and practices and shall provide suitable exceptions for emergency and temporary situations.

(d) The making of an agreement under section 716 with a group or other organization shall not operate to increase the payments to be made pursuant to any such agreement over the amounts which, in the absence of such group or organization, would be payable for the same services pursuant to agreements made under section 715 directly with the person or persons who furnish the services.

PROFESSIONAL RIGHTS AND RESPONSIBILITIES

SEC. 720. (a) Any person who enters into an agreement under this part may terminate such agreement after reasonable notice and after suitable arrangements are made to fulfill professional obligations to eligible individuals.

(b) Every physician, dentist, or nurse agreeing to render services as benefits under this title shall be free to practice his profession in the locality of his own choosing, consistent with the requirements of the laws of the States.

(c) Every physician, dentist, nurse, hospital, or other person entering into an agreement under this part shall be free to the extent consistent with applicable State law and customary professional ethics to accept or reject as a patient any individual requesting his services.

(d) No supervision or control over the details of administration or operation, or over the selection, tenure, or compensation of personnel, shall be exercised under the authority of this title over any hospital which has agreed to furnish personal health services as benefits.

PART D—LOCAL ADMINISTRATION

DECENTRALIZATION OF ADMINISTRATION

SEC. 731. In order that personal health-service benefits may be made available promptly and in a manner best adapted to local practices, conditions, and needs, responsibility for administration of the benefits provided under this title in the several local health service areas shall be decentralized as fully as practicable to local administrative committees or local administrative officers, acting with the advice and assistance, as provided in this part, of local professional committees and, in the case of local administrative officers, the advice and assistance of local area committees. The health-service areas of a State shall be those so designated in the State plan of operations.

LOCAL ADMINISTRATIVE COMMITTEE OR OFFICER

Sec. 732. The local administrative agency for each local health-service area may, as determined by the State, be either—

(1) a local administrative committee established in accordance with section 733, which shall act through a local executive officer;

(2) a local administrative officer, who shall act with the advice and assistance of a local advisory committee established in accordance with section 733.

The local administrative committee or officer, with the advice and assistance of such local professional committees as may from time to time be established, shall arrange for the furnishing of personal health-service benefits to eligible individuals in the area and to that end shall—

(a) publish, and make readily available to eligible individuals in the area, lists of the names of all persons who have agreed to furnish personal health services in the area, together with the class or classes of services which each has undertaken to furnish;

(b) disseminate pertinent information concerning the rights and privileges under this title of eligible individuals and of persons qualified to furnish personal health services as benefits;

(c) maintain effective relationships with physicians, dentists, nurses, hospitals, and other persons who have entered into agreements to furnish personal health services in the area, in order to facilitate the furnishing of such services in accordance with such agreements, to assure full and prompt payment to such persons for services so furnished, and to enlist their full cooperation in the administration of benefits under this title in the area:

(d) receive and, to the extent possible in the local area, adjust any complaints which may be made concerning the administration of benefits under this title in the area;

(e) perform such other duties (including the making of payments to persons furnishing personal health services in the area) as may be assigned by the State agency; and

(f) take or initiate such other administrative action as he finds will best carry out, within the area, the provisions of this title, and best effectuate its purposes.

LOCAL AREA COMMITTEES

Sec. 733. (a) A local area committee shall be established in each health-service area. If designated by the State as a local administrative committee, the local area committee shall perform the functions specified in section 732 and shall formulate policies for the administration of benefits under this title in the area. If designated as an advisory committee, it shall advise and assist in the performance of such functions and the formulation of such policies. The committee, whether administrative or advisory, shall participate in the solution of problems affecting the administration of such benefits, shall promote impartiality and freedom from political influence in such administration, and shall perform related functions to the end that administration in the area may be responsive to the wishes and needs of persons furnishing and receiving benefits in the area, be adapted to local practices and resources, and provide adequate and high-quality personal health services to all eligible individuals.

(b) Each local area committee shall consist of not less than eight nor more than sixteen members. The members shall be so selected that a majority of the committee shall be representative of the interests of individuals in the area who are eligible for benefits, and the remaining members shall be chosen from the several professions, hospitals, and other organizations in the area by whom such benefits will be provided.

(c) The local area committee shall meet as often as may be necessary, and whenever one-third or more of the members request a meeting; in the case of a local administrative committee, not less frequently than once each month, and in the case of a local advisory committee, not less frequently than once in each quarter of the year. At least one meeting of the committee each year shall be open to the public, notice of which shall be published and at which any person in the area may participate. At least once each year there shall be a State-wide meeting of local administrative officers and representatives of local administrative committees. At least once in each year there shall be a State-wide meeting of representatives of all local advisory committees in the State, and any reports or recommendations made at such meeting shall on the request of such meeting be transmitted through the State agency to the Board.

LOCAL PROFESSIONAL COMMITTEES

SEC. 734. Local committees representative of the persons furnishing personal health services in the area shall be established in each health-service area to assist the local administrative committee and its executive officer, or the local administrative officer and the local advisory committee, as the case may be, in the preservation of the customary freedom and responsibility (under applicable State law) of practitioners in the exercise of professional judgment as to the care of patients, and in the solution of technical problems concerning the participation of professional personnel, hospitals, and other qualified persons in the provision of personal health services as benefits, and to advise the local administrative or executive officer and the local area committee regarding matters of professional practice or conduct arising in connection with the performance of agreements for the provision of such services. Such local committees shall meet on call of the local administrative committee or officer, as the case may be, or upon their own motion. The members of any such local professional committee may be professional members of the local area committee or other professional persons or both.

METHODS OF ADMINISTRATION

SEC. 735. (a) In each health-service area the methods of administration shall be such as to—

(1) insure the prompt and efficient care of individuals entitled to personal health services as benefits;

(2) promote personal relationships between physician and patients;

(3) promote cordination among and between general practitioners, specialists, those who furnish auxiliary services, nurses, and hospitals, in the furnishing of services under this title, between them and public-health centers and agencies, and educational service, research, and other related agencies or institutions, and between preventive, diagnostic, and curative services, public and private;

(4) aid in the prevention of disease, disability, and premature death;

(5) encourage improvement in the number and distribution of professional personnel and facilities; and

(6) insure the provision of adequate service with the greatest economy consistent with high standards of quality.

(b) Local administrative officers shall be appointed by the State agency or the head thereof, in accordance with the merit system provided for in the State plan of operations; local administrative committees shall be appointed by such agency or the head thereof, from individuals residing in the respective health-service areas, and the executive officers of such committees shall be appointed by the committees in accordance with the merit system; the local health-service areas shall be those so designated in such plan; and members of local advisory committees and of local professional committees shall be selected in accordance with methods set forth in such plan.

(c) In exercising their functions and discharging their responsibilities under this title local administrative officers and communities, local advisory committees, and local professional committees shall observe the provisions of this title, and of regulations prescribed thereunder, and of any regulations, standards, and procedures prescribed by the State agency.

PART E—STATE ADMINISTRATION

DECLARATION OF POLICY

SEC. 741. It is the intent of Congress that the benefits provided under this title be administered wherever possible by the several States, in accordance with plans of operations submitted and approved as provided in this part, and in each State insofar as feasible by the same State agency which administers, or supervises the administration of, the State's general public health and maternal and child-health programs.

STATE PLAN OF OPERATIONS

SEC. 742. (a) Any State desiring to assume responsibility for the administration in the State of the personal health-service benefits provided under this title to all individuals in the State who are eligible for such benefits, may do so for the period beginning July 1, 1951 (when benefits first become available under this title), or for the period beginning July 1 of any succeeding year, if it has undertaken, through its legislature, to administer such benefits in accordance with the provisions of this title and with the provisions of regulations and standards prescribed thereunder, and, at least twelve months in advance, has submitted and had approved a State plan of operations which—

(1) designates as the sole agency for the State-wide administration of benefits under this title a single State agency duly authorized under the law of the State to administer such benefits within the State in accordance with the provisions of this title, the provisions of regulations and standards prescribed thereunder, and the provisions of the State plan;

(2) provides for the designation of a State advisory committee which shall include members who are familiar with the needs for personal health services in urban and rural areas, and who are representative of the interests of individuals in the State who are eligible for benefits, such members to constitute a majority, and members chosen from the several professions, hospitals, and other organizations in the State by whom such benefits will be provided, to advise the State agency in carrying out the administration of such benefits in the State;

(3) provides for the decentralized administration of this title in the State in accordance with part D for the designation of local health-service areas, and for such methods of selecting the members of local advisory committees and of local professional committees as are calculated to insure representation of the nature set forth in sections 733 and 734, respectively;

(4) provides such methods of administration, including methods relating to the establishment and maintenance of personnel standards on a merit basis (except that the Board shall exercise no authority with respect to the selection, tenure of office, or compensation of any individual employed in accordance with such methods), as are found by the Board to be necessary for the proper and efficient administration of such benefits in the State;

(5) provides for the making of surveys of the resources and needs of the State, in accordance with section 702 (a), and sets forth a program for the administration of such benefits in the State which gives reasonable assurance (A) that maximum use will be made of all available health personnel and facilities desiring to participate in the provision of benefits to eligible individuals, (B) that funds allotted to the State for the several classes of benefits will be allocated in such manner as to give reasonable assurance of the availability of services in all health-service areas in the State, and (C) that any maldistribution or other inadequacies in the health personnel or facilities available for such purpose, or in the quality of the services rendered, will be progressively improved as rapidly as may be practicable;

(6) provides that the State agency will make such reports in such form and containing such information as the Board may from time to time reasonably require, and give the Board, upon demand, access to the records upon which such information is based;

(7) provides that all Federal funds paid to the State agency for purposes of carrying out this title in the State shall be properly safeguarded and expended solely for the purposes for which paid, and provides for the repayment by the State to the United States of any such funds lost by the State agency or diverted from the purposes for which paid;

(8) provides for cooperation, including where necessary entering into working agreements (with any appropriate transfer of funds), with other public agencies of the State or of its political subdivisions concerned with programs related to the purposes of this title, and with appropriate agencies of other States or of the United States administering this title, or benefits under this title, in other States.

(b) The Board shall approve any State plan and any modification thereof submitted by the State which it finds complies with the provisions of subsection (a). No change in a State plan shall be required within one year after initial approval thereof, or within one year after any change thereafter required therein, by reason of any change in the regulations or standards prescribed pursuant to this title, except with the consent of the State or in accordance with further action by Congress.

(c) In the event of its disapproval of any plan or any modification therein submitted by a State pursuant to this part, the Board shall notify the State of such disapproval, and shall, upon request of the State, afford it reasonable notice and opportunity for a hearing on such disapproval.

(d) If a State has not prior to July 1, 1950, submitted and had approved a plan of operations, the Board shall notify the Governor of the State that the Board will be required to administer this title in the State, commencing July 1, 1951. The Board shall provide for the publication of such notice in at least two newspapers of general circulation in the State. If within sixty days after such notification to the Governor the State has not submitted an approvable plan, the Board shall undertake the administration of this title in the State commencing July 1, 1951, and shall continue such administration until one year after the submission and approval of a plan of operations in accordance with this section: *Provided*, That the Board may waive the requirement that a State plan must be submitted and approved one year prior to commencement of State administration if it is satisfied in a particular case that the substitution of a shorter preparatory period will not prejudice the interests of eligible individuals in the State.

(e) Whenever the Board, after reasonable notice and opportunity for hearing to the State, finds that the State, having submitted and had approved a plan of operations under this part—

(1) is not complying substantially with the provisions of such plan, or with the provisions of this title or any regulations or standards prescribed thereunder, or

(2) has withdrawn its plan or failed to change it when and as required by a change in this title or in regulations prescribed thereunder,

the Board shall notify the Governor of the State of such findings, together with its reasons therefor and a statement concerning the effect of such findings under this title, and shall provide for the publication of such notice in at least two newspapers of general circulation in this State. If within sixty days following such a notice the State has not taken appropriate action to bring its plan or its administration thereof into conformity with this title and regulations and standards thereunder, the Board shall immediately assume responsibility for the administration of this title in the State and shall administer the same in such State for so long thereafter as the State fails to give reasonable assurances of substantial compliance or fails to submit an approvable plan, as the case may be.

(f) In any State in which the Board has assumed responsibility for the administration of benefits under this title as provided in subsections (d) and (e) of this section, the Board shall have and discharge all authority and duties, in accordance with the provisions of this title, which it finds necessary for that purpose, and the term "State agency" wherever used in part C or part D of this title shall be deemed to refer to the Board.

(g) Nothing in this title shall preclude any State or any political subdivision thereof, whether or not the State has assumed responsibility for the administration of benefits under this title, from furnishing, with funds available from sources other than the account, any additional health services to individuals who are eligible for benefits under this title or any or all health services to individuals who are not so eligible.

PART F—NATIONAL HEALTH INSURANCE BOARD; NATIONAL ADVISORY MEDICAL POLICY COUNCIL; GENERAL ADMINISTRATIVE PROVISIONS

NATIONAL HEALTH INSURANCE BOARD

SEC. 751. (a) There is hereby established in the Federal Security Agency a National Health Insurance Board (referred to in this title as the "Board"), to be composed of five members, three of whom shall be appointed by the President by and with the advice and consent of the Senate, and the other two of whom shall be the Surgeon General of the Public Health Service and the Commissioner for Social Security. During his term of membership on the Board, no appointed member shall engage in any other business, vocation, or employment. At least one of the appointed members shall be a doctor of medicine licensed to practice medicine or surgery in one of the States. Each appointed member shall receive a salary at the rate of $12 000 a year and shall hold office for a term of six years, except that (1) any member appointed to fill a vacancy occurring prior to the expiration of the term for which his predecessor was appointed shall be appointed for the remainder of such term; and (2) the terms of office of the members first taking office after the date of the enactment of this Act shall expire, as designated by the President at the time of appointment, one at the end of two years, one at the end of four years, and one at the end of six years, after the date of the enactment of this Act. The President shall designate one of the appointed members as the Chairman of the Board.

(b) All functions of the Board shall be administered by the Board under the direction and supervision of the Federal Security Administrator. The Board shall perform such functions as it finds necessary to carry out the provisions of this title, and shall make all regulations and standards specifically authorized to be made in this title and such other regulations not inconsistent with this title as may be necessary. The Board may delegate to any of its members, officers or employees, or with the approval of the Administrator to any other officer or employee of the Federal Security Agency, such of its powers or duties, except that of making regulations, as it may consider necessary and proper to carry out the provisions of this title. The Board may also enter into agreements for the furnishing or provision of personal health services under this title without regard to civil service or other laws pertaining to the appointment, status, or conpensation of Federal employees, or pertaining to contracts for personal services, and without regard to section 3709 of the Revised Statutes, as amended, and any person rendering services pursuant to an agreement so made shall not by reason thereof be deemed to be an employee of the United States.

(c) In administering the provisions of this title, the Board is authorized to utilize the services and facilities of any executive department or other agency of the United States in accordance with an agreement with the head thereof. Payment for such services and facilities shall be made in advance or by way of reimbursement, as may be agreed upon with the head of the executive department or other agency furnishing them.

(d) Personnel of the Board shall be appointed by the Administrator upon recommendation of the Board. The Administrator is authorized to detail to the Board, upon its request, any officer or employee of the Federal Security Agency, and in his discretion to reimburse, from funds available for the administration of this title, the appropriation from which the salary or, in the case of commissioned officers of the Public Health Service, the pay and allowances of such officer or employee are paid.

(e) Upon the request of any State agency administering a State plan of operations pursuant to part E of this title, or upon the request of any State desiring to prepare and submit a plan of operations, any officer or employee of the Board (including any officer or employee detailed to the Board pursuant to subsection (d)) may be detailed by the Board to assist in the administration, or in the preparation, of such State plan of operations. The funds available for the Federal administration of this title may, in the discretion of the Administrator, be reimbursed from funds allotted to the State pursuant to section 772 and available for State administration, for the salary (or for the pay and allowances) of any officer or employee so detailed.

ADVISORY COUNCIL

SEC. 752. (a) There is hereby established a National Advisory Medical Policy Council (referred to in this title as the "Advisory Council") to consist of the Chairman of the Board, who shall serve as Chairman of the Advisory Council ex officio, and sixteen members appointed by the Federal Security Administrator. At least eight of the sixteen appointed members shall be individuals who are familiar with the need for personal health services in urban or rural areas and who are representative of the interests of individuals eligible for benefits under this title, and at least six of the members shall be individuals who are outstanding in the medical or other professions concerned with the provision of services provided as benefits under this title and who are representative of the individuals, organizations, and other persons by whom personal health services will be provided. Each appointed member shall hold office for a term of four years, except that any member appointed to fill a vacancy occurring prior to the expiration of the term for which his predecessor was appointed shall be appointed for the remainder of that term, and the terms of the members first taking office shall expire, as designated by the Administrator at the time of appointment, four at the end of the first year, four at the end of the second year, four at the end of the third year, and four at the end of the fourth year after the date of appointment. The Advisory Council is authorized to appoint such special advisory technical or professional committees as may be useful in carrying out its functions, and the members of such committees may be members of the Advisory Council, or other persons, or both. Appointed Advisory Council members and members of technical or professional committees, while serving on business of the Council (inclusive of travel time), shall receive compensation at rates fixed by the Administrator, but not exceeding $25 per day; and shall be entitled to receive actual and necessary traveling expenses and per diem in lieu of subsistence while so serving away from their places of residence. The Advisory Council, its appointed members, and its committees, shall be provided with such secretarial, clerical, or other assistance as may be provided by the Congress for carrying out their respective functions. The Advisory Council shall meet as frequently as the Board deems necessary, but not less than twice each year. Upon request by six or more members, it shall be the duty of the Chairman to call a meeting of the Council.

(b) The Advisory Council shall advise the Board with reference to matters of general policy and administration arising in connection with the making of regulations, the establishment of professional standards, and the performance of its other duties under this title.

STUDIES, RECOMMENDATIONS, AND REPORTS

SEC. 753. The Board shall have the duty of studying and making recommendations as to the most effective methods of providing health services, and as to legislation and matters of administrative policy concerning health and related subjects. At the beginning of each regular session of Congress, it shall make a full report to Congress of the administration of this title, including a report with regard to the adequacy of its financial provisions contained in this title and of appropriations made pursuant thereto, the methods of allotment of funds among the States, and related matters. Such report shall include a record of consultations with the Advisory Council, recommendations of the Advisory Council, and comments thereon.

NONDISCLOSURE OF INFORMATION

SEC. 754. Information concerning an individual, obtained from him or from any physician, dentist, nurse, or hospital, or from any other person pursuant to or as a result of the administration of this title, shall be held confidential (except for statistical purposes) and shall not be disclosed or be open to public inspection in any manner revealing the identity of the individual or other person from whom the information was obtained or to whom the information pertains, except as may be necessary for the proper administration of this title or of other laws, State or Federal. Any person who shall violate any provision of this section shall be deemed guilty of a misdemeanor and, upon conviction thereof, shall be punished by a fine not exceeding $1,000 or by imprisonment not exceeding one year, or both.

PROHIBITION AGAINST DISCRIMINATION

SEC. 755. In carrying out the provisions of this title, there shall be no discrimination on account of race, creed, or color. Personal health services shall be made available as benefits to all eligible individuals, and all persons qualified under part C to enter into agreements to furnish or provide such services shall be permitted to do so.

PART G—ELIGIBILITY DETERMINATIONS, COMPLAINTS, HEARINGS, AND JUDICIAL REVIEW

DETERMINATIONS AS TO ELIGIBILITY FOR BENEFITS

SEC. 761. (a) The Federal Security Administrator, through such units of the Federal Security Agency as he may determine, shall upon his own initiative or upon application of any individual make determinations as to the eligibility of individuals for benefits under this title. Whenever requested by any individual determined by the Federal Security Administrator not to be eligible for benefits for any period, or by a dependent of any such individual, the Administrator shall give such individual or such dependent reasonable notice and opportunity for a hearing with respect to such determination and on the basis of the evidence adduced at the hearing shall affirm, modify, or reverse his determination.

(b) In carrying out his responsibility under this section, the Administrator shall have all the powers and duties conferred upon him under sections 205 and 206 of the Social Security Act, as amended. Such powers and duties shall be subject to the same limitations and rights of judicial review as are contained in section 205 of such Act. Eligibility for benefits under this title based on entitlement to an annuity under the Civil Service Retirement Act, as amended shall be determined on the basis of certification by the Civil Service Commission.

(c) Nothing in part E of this title shall be deemed to require or authorize any assumption by the State agency, designated in accordance with an approved State plan of operations approved under such part, of any of the Administrator's responsibilities under this section, but the Administrator may utilize existing facilities and services of any such agency on the basis of mutual agreements with such agency.

COMPLAINTS OF ELIGIBLE INDIVIDUALS AND OF PERSONS FURNISHING BENEFITS

SEC. 762. (a) Any eligible individual aggrieved by reason of his failure to receive any personal health-service benefits to which he believes himself entitled, or dissatisfied with any service rendered him as a personal health-service benefit, and any person who has entered into an agreement to furnish services as personal health-service benefits and who is aggrieved by the failure or alleged failure of a local or other administrative officer or a local administrative committee to carry out the agreement in accordance with its terms, may make a complaint to the local administrative officer or local executive officer in the area in which the action or inaction complained of occurred, or to such other officer as may be provided in regulations. If the officer to whom such complaint is made finds, after investigation, that the complaint is well-founded, he shall promptly take such steps as may be necessary and appropriate to correct the action or inaction complained of; and he shall notify the individual or other person making the complaint of his disposition thereof. Any such individual or other person dissatisfied with the action taken may in writing request a hearing thereon and shall be afforded opportunity for the same pursuant to subsection (b) of this section.

(b) Provision shall be made for the establishment of necessary and sufficient impartial tribunals to afford hearings to individuals and other persons entitled thereto under subsection (a) of this section, or section 717 (d) of this title, and for further review of the findings, conclusions, and recommendations of such tribunals, in accordance with regulations made by the Board, after consultation with the Advisory Council. With respect to any complaint involving matters or questions of professional practice or conduct, the hearing body shall contain competent and disinterested professional representation; and with respect to any complaint involving only matters or questions of professional practice or conduct the hearing body shall consist exclusively of such professional persons.

(c) In administering this section in any State which has not assumed responsibility for the administration of benefits under this title as provided in part E, the Board (subject to the provisions of section 751 (b)) shall, insofar as they are applicable to its functions under this title, have all the powers and duties conferred upon the Federal Security Administrator by sections 205 and 206 of the Social Security Act, as amended. Such powers and duties shall be subject to the limitations and rights of judicial review contained in section 205 of such Act.

(d) In any State which has assumed responsibility for the administration of benefits under this title as provided in part E the powers and duties of the State agency shall be subject to such rights of judicial review in the courts of the State as the law of the State may provide; subject, however, to review by the Supreme Court of the United States in such cases and in such manner as is provided in section 237 of the Judicial Code, as amended.

PART H—FISCAL PROVISIONS

PERSONAL HEALTH SERVICES ACCOUNT

SEC. 771. (a) There is hereby created on the books of the Treasury of the United States a separate account to be known as the "Personal Health Services Account" (in this title, referred to as the "account"). Funds in the account not required for current withdrawals shall be investigated by the Secretary of the Treasury in the types of obligations which may be acquired by the Federal Old-Age and Survivors Insurance Trust Fund, and in accordance with provisions governing such investments in section 201 (c) to (e), inclusive, of the Social Security Act, as amended. Funds in the account shall be available for all expenditures necessary or appropriate to carry out this title; except that (subject to the provisions of section 772 (g)) only so much of such funds shall be available for salaries or other administrative expenses of any department or agency of the United States as may be authorized in annual or other appropriation Acts.

(b) There shall be appropriated to the account for the fiscal year ending June 30, 1952, and for each fiscal year thereafter—

(1) sums equal to 3 per centum of all wages estimated to be received during such fiscal year;

(2) sums equal to the estimated cost of furnishing dental services and home-nursing services as personal health-service benefits during such fiscal year; and

(3) any further sums required to meet expenditures to carry out this title.

(c) There shall be appropriated to the account in the fiscal year 1951, a sum equal to 1 per centum of all wages estimated to be received during such fiscal year, to constitute on July 1, 1951, a reserve in the account for the purposes specified in section 772 (a).

(d) The aggregate appropriations to the account, pursuant to clauses (2) and (3) of subsection (b), in appropriation Acts for any fiscal year from 1952 to 1954, inclusive, shall not exceed one-half per centum, and in appropriation Acts for any fiscal year from 1955 to 1957, inclusive, shall not exceed 1 per centum of the estimated annual average of all wages received during the three fiscal years preceding such fiscal year. Whenever an appropriation is made on the basis of an estimate of wages to be received during a fiscal year, the appropriations for subsequent fiscal years shall be adjusted by any amount by which such estimate was greater or less than the amount of wages actually received. Before January 1, 1957, and periodically thereafter, the Congress will review this title and will determine the amounts of appropriations to be made thereafter.

(e) Sums received as reimbursements to the account pursuant to section 704 (c) or section 705, or by virtue of subrogation pursuant to section 704 (c), shall be deposited in the account and shall be available in accordance with the provisions of subsection (a) of this section.

ALLOTMENT OF FUNDS

SEC. 772. (a) The Board, after consultation with the Advisory Council, shall determine, as far in advance of the beginning of each fiscal year as possible, the sums which shall be available from the account for provision during the fiscal year of all classes, and of each of the five classes, of personal health-service benefits specified in section 701 (a). Such sums shall be determined, after taking into consideration the estimated amount which will be in the account at the beginning of the fiscal year and the anticipated income of the account thereafter, with a view (1) to maintaining as nearly as practicable a uniform rate of expenditure for personal health-service benefits in successive fiscal years, except for appropriate allowance on account of anticipated increase in the personnel and facilities available to furnish personal health-service benefits and on account of reduction or withdrawal of restrictions or limitations pursuant to section 702 (b), and (2) to establishing and maintaining a reserve in the account adequate to meet emergency demands in accordance with subsection (d) of this section and adequate to maintain the rate of expenditure or to permit its gradual reduction if the income of the account should fall below the income which had been anticipated.

(b) In accordance with regulations prescribed after consultation with the State agencies, the Board, prior to the beginning of each fiscal year shall allot to the several States, for the fiscal years 1952, 1953, and 1954, 90 per centum, and for each fiscal year thereafter 95 per centum of each sum determined pursuant to subsection (a). Such regulations shall provide for allotments on the basis of—

(1) the population in the several States eligible for benefits under this title;

(2) professional and other personnel, hospitals, and other facilities, and supplies and commodities, to be available in the several States in the provision of such benefits; and

(3) the cost of reasonable and equitable compensation to such personnel and facilities and for such supplies and commodities.

Such allotments shall operate, to the maximum extent possible both to assure provision to eligible individuals of adequate personal health-service benefits in all States and all local health-service areas, and also to increase the adequacy of services where personnel and facilities are below the national average.

(c) From time to time during each fiscal year, the Board shall allot to the several States the remaining 10 per centum or the remaining 5 per centum, as the case may be, of each sum determined pursuant to subsection (a). In making allotments under this subsection, the Board shall take into consideration the factors specified in subsection (b), but shall in addition, give special consideration to the extent to which allotments under subsection (b) have proved to be insufficient to permit provision of reasonably adequate benefits under this title.

(d) In addition to the sums determined pursuant to subsection (a) to be available for the provision of personal health-service benefits, the Board, after consultation with the Advisory Council, is authorized to make emergency allotments from the account if it finds that a disaster, epidemic, or other cause has substantially increased the volume of personal health-service benefits required in any part of the United States over the volume anticipated when the determinations pursuant to subsection (a) were made. Allotments pursuant to this subsection shall be made to such State or States, for such class or classes of personal health-service benefits, and in such amounts, as the Board may find necessary to meet the emergency.

(e) The Board shall from time to time determine the amounts to be paid to each State from its allotments under this section, and shall certify to the Secretary of the Treasury the amounts so determined. The Secretary shall thereupon, and prior to audit or settlement by the General Accounting Office, pay to the State the amounts so certified.

(f) Funds paid to a State for any class of personal health-service benefits shall be used exclusively for the provision of benefits of that class, except that the administrative costs of the State in administering personal health-service benefits under this title may be met from the allotments to the State. Such administrative costs, which in any fiscal year shall not exceed 5 per centum of the aggregate allotments to the State for such fiscal year, shall be apportioned as between the several allotments in accordance with the costs of administering the respective classes of benefits; and such apportionment may be made in such manner, and by such sampling, statistical, or other methods, as may be agreed upon between the Board and the State agency.

(g) In any case in which the Board has assumed responsibility for the administration in a State of benefits under this title in accordance with section 742 (d) or (e), all allotments or balances of allotments to such State shall be available for expenditure by the Board for the provision of personal health-service benefits in that State, and (until the Congress shall make funds available therefor pursuant to section 771 (a)) for the costs of administration of such benefits in such State. Expenditures authorized pursuant to section 771 (a) for such costs of administration shall be charged against allotments to such State.

GRANTS-IN-AID FOR TRAINING AND EDUCATION

SEC. 773. (a) For the purpose of increasing the availability of training and education for professional and technical personnel engaged or undertaking to engage in the provision or administration of personal health services as benefits under this title, and to carry out the policies of section 719 (a), the Board is authorized to make grants—

(1) to public or nonprofit institutions or agencies engaging in undergraduate or postgraduate professional, technical, or administrative education or training, for the cost (in whole or in part) of courses or projects which the Board finds, after consultation with the Advisory Council and appropriate Federal departments and agencies, (A) cannot be carried out without financial assistance under this section, and (B) show promise of making valuable contributions to the education, training, or retraining of professional or technical personnel engaged or undertaking to engage in the provision or administration of benefits, or

(2) to individuals who are professional or technical persons engaged or who undertake to engage in the provision of personal health-service benefits, or who are engaged or undertake to engage in the administration of such benefits, for maintenance (in whole or in part) while in attendance at courses or projects assisted under paragraph (1) or approved by the Board for similar training or education, and for costs of necessary travel.

(b) Such grants, in such amounts and for payment at such times as are approved by the Board, shall be certified for payment to the Secretary of the

Treasury. who shall pay them from the account to the designated individuals, institutions, or agencies.

(c) For the purposes of this section there shall be available for the fiscal year 1952 the sum of $10,000,000, for the fiscal year 1953 the sum of $15,000,000, and for each fiscal year thereafter an amount not to exceed one-half of 1 per centum of the amount expended for benefits under this title in the last preceding calendar year.

Part I—Miscellaneous Provisions, Definitions

Sec. 781. As used in this title—

(a) The term "wages" means the sum of the following items, excluding any amount in excess of $4,800 received (or, in the case of income from self-employment, accrued) by any individual during any calendar year—

(1) all remuneration for employment, including the cash value of all remuneration paid in any medium other than cash; except that such term does not include—

(A) the amount of any payment made to, or on behalf of, an employee under a plan or system established by an employer which makes provision for his employees generally or for a class or classes of his employees (including any amount paid by an employer for insurance or annuities, or into a fund, to provide for any such payment), on account of retirement, or sickness or accident disability, or medical and hospitalization expenses in connection with sickness or accident disability, or death; provided, in the case of a death benefit, that the employee (i) has not the option to receive, instead of provision for such death benefit, any part of such payment or, if such death benefit is insured, any part of the premiums (or contributions to premiums) paid by his employer, and (ii) has not the right, under the provisions of the plan or system or policy of insurance providing for such death benefit, to assign such benefit, or to receive a cash consideration in lieu of such benefit either upon his withdrawal from the plan or system providing for such benefit or upon termination of such plan or system or policy of insurance or of his employment with such employer;

(B) the payment by an employer (without deductions from the remuneration of the employee) of any social-insurance taxes or contributions imposed upon an employee; or

(C) the value of services exchanged for other services for which there is no payment other than the exchange; and

(2) all net income from farm, business, professional, or other self-employment.

(b) The term "employment" means any service of whatever nature performed by an employee for the person employing him, irrespective of the citizenship of residence of either, (A) within the United States, or (B) on or in connection with an American vessel or an American civil aircraft under a contract of service which is entered into within the United States or during the performance of which the vessel or aircraft touches at a port or airport in the United States, if the employee is employed on and in connection with such vessel or aircraft when outside the United States, except—

(1) service in the active military or naval service of the United States;

(2) service performed in the employ of a State or any political subdivision thereof, or any instrumentality of any one or more of the foregoing which is wholly owned by one or more States or political subdivisions;

(3) casual labor not in the course of the employer's trade or business;

(4) service performed by an employee on or in connection with a vessel not an American vessel, or an aircraft not an American aircraft, if the employee is employed on and in connection with such vessel or aircraft when outside the United States;

(5) service performed by a duly ordained or duly commissioned or licensed minister of any church in the regular exercise of his ministry and service performed by a regular member of a religious order in the exercise of duties required by such order;

(6) service performed by an individual as an employee or employee representative as defined in section 1 of the Railroad Retirement Act of 1937, as amended;

(7) service performed in any calendar quarter in the employ of any organization exempt from income tax under section 101 of the Internal Revenue Code; if—

(A) the remuneration for such service does not exceed $45; or

(B) such service is in connection with the collection of dues or premiums for a fraternal beneficiary society, order, or association, and is performed away from the home office or is ritualistic service in connection with any such society, order, or association; or

(C) such service is performed by a student who is enrolled and is regularly attending classes at a school, college, or university;

(8) service performed in the employ of a foreign government (including service as a consular or other officer or employee or a nondiplomatic representative);

(9) service performed in the employ of an instrumentality wholly owned by a foreign government, if—

(A) the service is of a character similar to that performed in foreign countries by employees of the United States Government or of an instrumentality thereof; and

(B) the Secretary of State shall certify to the Federal Security Administrator that the foreign government, with respect to whose instrumentality and employees thereof exemption is claimed, grants an equivalent exemption with respect to similar service performed in the foreign country by employees of the United States Government and of instrumentalities theerof; and

(10) service performed in the employ of an international organization entitled to enjoy privileges, exemptions, and immunities as an international organization under the International Organizations Immunities Act.

(c) In any case in which an individual has received $4,800 in wages in a calendar year, not less than $150 of such wages shall be deemed, for the purpose of section 704 (a), to have been received by him in the quarter during which the first of such wages were in fact received by him and in each quarter of such calendar year thereafter.

(d) The term "benefit year" means a period commencing on July 1 of any year and ending on June 30 of the succeeding year.

(e) The term "quarter" and the term "calendar quarter" mean a period of three calendar months ending on March 31, June 30, September 30, or December 31.

(f) The term "employee" includes (in addition to any individual who is a servant under the law of master and servant) any individual who performs service, of whatever nature, for a person, unless the service is performed by the individual in pursuit of his own independently established business. The term "employee" also includes an officer of a corporation.

(g) The term "American vessel" means any vessel documented or numbered under the laws of the United States, and includes any vessel which is neither documented nor numbered under the laws of any foreign country, if its crew is employed solely by one or more citizens or residents of the United States or corporations organized under the laws of the United States or of any State.

(h) The term "American aricraft" mean an aircraft registered under the laws of the United States.

(i) The term "State" includes Alaska, Hawaii, and the District of Columbia.

(j) The term "United States," when used in a geographic sense, means the several States, as defined in subsection (i).

(k) The term "dependent" means an unmarried child (including a stepchild, adopted or foster child) of an individual, who is under the age of eighteen, or who is under a total disability which has continued for a period of not less than six consecutive calendar months and is living with such individual or receiving regular support from him; a wife of an individual living with such individual or receiving regular support from him; a husband who is under a total disability which has continued for a period of not less than six consecutive calendar months, and is living with or receiving regular and substantial support from such individual; and a parent who is living with or receiving regular and substantial support from such individual.

(l) The term "person" means an individual, a trust or estate, a partnership, a corporation, an association, a consumer cooperative, or other organization.

AVAILABILITY OF PUBLIC ASSISTANCE GRANTS FOR SECURING PERSONAL HEALTH-SERVICE BENEFITS

SEC. 782. In order that Federal grants to States for old-age assistance, aid to dependent children, and aid to the blind shall be available to all States for provision of benefits for noninsured needy individuals, as provided in section 705—

(a) Title I of the Social Security Act, as amended, is amended—

(1) By amending section 6 to read:

"SEC. 6. When used in this title the term 'old-age assistance' means money payments to needy aged individuals, and reimbursements to the Personal Health Services Account with respect to needy aged individuals.";

(2) By striking out in section 3 (a) "not counting so much of such expenditure" and inserting in lieu thereof "not counting so much of any money payment"; and by striking out in clause (A) of such subsection "who received old-age assistance" and inserting in lieu thereof "who received money payments".

(b) Title IV of such Act is amended—

(1) By amending section 406 (b) to read:

"(b) The term 'aid to dependent children' means money payments, and reimbursements to the Personal Health Services Account, with respect to a dependent child or dependent children.";

(2) By striking out in section 403 (a) "not counting so much of such expenditure" and inserting in lieu thereof "not counting so much of any money payment"; and by striking out in clause (A) of such subsection "with respect to whom aid to dependent children is paid" and inserting in lieu thereof "with respect to whom money payments are made."

(c) Title X of such Act is amended—

(1) By amending section 1006 to read:

"SEC. 1006. When used in this title the term 'aid to the blind' means money payments to blind individuals who are needy, and reimbursements to the Personal Health Services Account with respect to blind individuals who are needy."

(2) By striking out in section 1003 (a) "not counting so much of such expenditure" and inserting in lieu thereof "not counting so much of any money payment"; and by striking out in clause (A) of such subsection "who received aid to the blind" and inserting in lieu thereof "who received money payments."

EFFECTIVE DATE

SEC. 783. The effective date of this title shall be the date of its enactment, but personal health services shall first become available as benefits in accordance with this title on July 1, 1951.

Senator MURRAY. I know the members of the subcommittee will share my keen regret that Senator Thomas is unable to be with us this morning to present his statement in person. He is presiding over a subcommittee which is now conducting hearings on the international wheat agreement. Were it a matter of lesser importance or lesser eminence, he would be here to testify this morning. However, Senator Thomas has given me his prepared statement and it will be inserted in the record at this point.

(The statement of Senator Thomas, in full, is as follows:)

STATEMENT OF HON. ELBERT D. THOMAS, A UNITED STATES SENATOR FROM THE STATE OF UTAH, AND CHAIRMAN OF THE SENATE COMMITTEE ON LABOR AND PUBLIC WELFARE

It is a source of honor and pride to me to have been privileged to associate myself with the forward looking Senators who, for many years, have again and again introduced health bills and who have traveled the long weary road through hearings, committee discussions, and other forms of leadership in this field, only to be met with the same temporary frustrations which are the lot of all crusaders.

To have been given the opportunity to be first signer of this bill, in view of the intense activity of others in its behalf, seems a bit of a steal, but because I am chairman of the committee which has jurisdiction over public welfare as well as labor, and because I believe that denial of proper medical attention belongs with the dark ages we have left behind, I shall try to give as much energy toward bringing out the desired goal as I am capable of exerting.

In general terms it is not hard to understand the problem or to suggest its solution. It is a problem that has been with us since the beginning of time. It was the principal problem confronting the Saviour, the miracle of many whose cures has not yet been found in the beakers and test tubes of our modern laboratories.

The miracle of cure, however, lies behind scientific research and development not yet undertaken or completed. The discovery of long life through scientific endeavor is a rich testimonial to the doctors and nurses of this and immediately preceding generations. To me it is a recognition of not only their services but their sacrifices that we undertake to extend the degree of their usefulness into houses whose timid purses lack the temerity to appeal for proper health protection.

In preventive medicine, the people of the world are babies groping for light. The diseases of the past have burdened us with the need for concentration of our energies upon their cure. Some strike with lightning velocity and appear to decimate whole populations before they can catch their breath in retaliation; usually the retaliation of the development of specific immunities rather than of immediately effective medical preparations and devices. Against these obstacles, the doctors have given us longevity which, in turn, has presented new obstacles and emphasis on such physical deficiencies as heart disease and cancer, neither of which obviously would have developed in a man or woman past middle age if that person had died young of some other disease. This emphasis has caused scientific inquiries of its own, so that longevity may be enjoyed if not extended.

On the whole, this has been a bewildering century, not less so in medicine than in any other development. Our adjustments to the technological changes should be no less sensible than in any other field. In fact, public health is perhaps the prime essential of community living, and one's own health certainly is the individual's most coveted pursuit.

The rest is a matter of detail. These hearings should demonstrate, as they have in the past, that if we but will, we who pay taxes and we who are accustomed to paying insurance premiums can pay our way through the ordinary modest medical necessities; and those of us who, because of our own poverty or an overdose of bad medical fortune, cannot meet our supposed obligations, will not be a too heavy burden upon those others of us who trip through life gaily without scar or blemish.

This is true in the same way that we did not fail when men, women, and children were hungry or unsheltered in the difficult 1930's. It is true of the young men whose bodies were emaciated by patriotic response to the colors in the long months of war.

There will be those who will present staggering mathematics in open ridicule of any attempt to succor the unfortunate, however modest the figure. It is said that organizations once bitterly opposed to any plan which they contemptuously called socialized medicine a decade ago now openly advocate and endorse public-health plans which have the same features which they opposed at that time.

These are incidents which we must cut through if we are to get anywhere in the present hearings. The reasonable public purse may be opened. No one wishes to attempt the impossible. The authors of these bills are not men whose records would indicate any except a very hardheaded, practical, businesslike approach to the improvement of present health conditions.

Not one of these has failed to enjoy with grateful appreciation the kindly services of his skillful doctor or doctors, but regards the practice and those who engage in it with the highest esteem. It is throwing dust into the eyes of the followers of this movement to make it appear otherwise.

I have not the remotest idea that the same individual who takes the Hippocratic oath and lives up to its demanding features is a grasping, selfish creature whom some zealots have described him to be. Neither are the proponents of adequate medical care suspect. The 1949 hearings bid fair to erase some of the mistrust and calumny that have flavored the approach of some extremists in both camps in the early days of this struggle. It would appear to me that Chairman Murray of the subcommittee on health, and our staff which has worked tirelessly in the preparation of a proper program, have made unusual attempts to see to it that the subject is dealt with fairly. Certainly it will be considered intelligently.

Senator MURRAY. In view of the necessary absence of Senator Thomas, our first witness will be Mr. Donald Kingsley who will present the Federal Security Agency's position on the bills before us. While we are very glad to have Mr. Kingsley appear before us, I should like the record to show our extreme regret that the Honorable Oscar R.

Ewing, Federal Security Administrator, has not yet recovered sufficiently from a serious illness to be able to appear personally. So Mr. Kingsley will be the first witness this morning.

STATEMENT OF J. DONALD KINGSLEY, ACTING FEDERAL SECURITY ADMINISTRATOR

Mr. KINGSLEY. Mr. Chairman and members of the subcommittee, I appreciate this opportunity to represent the administration in support of President Truman's program for the Nation's health. I regret the fact that Mr. Oscar Ewing, the Federal Security Administrator, cannot be here as the spokesman for a program to which he has contributed so much and which is so close to his heart. He still is convalescing from a prolonged illness, as the chairman said. Although he has returned part-time to his desk, he is not yet equal to any unusual strain.

At the request of the chairman, we have filed report on four bills, S. 1106, S. 1456, and S. 1679. The first is covered in a separate report, since it has little in common with the others and is concerned primarily with the provision of expensive drugs, diagnostic services, and so forth. As for the other three, we have combined our detailed observations under topical headings, comparing the different proposals as they relate to medical care, facilities, services, personnel, research, hospital construction, public health services, and maternal, and child health.

I understand that the hearings opening this morning are to be general in nature—dealing broadly with our national health problems and the various bills before this committee—and that more detailed and specific testimony should be reserved to the time when the separate titles of these bills are considered.

I should like to begin by quoting briefly from President Truman's special message to the Congress of April 22, 1949. In that message, as you will recall, he said:

> Good health is the foundation of a nation's strength. It is also the foundation upon which a better standard of living can be built for individuals. To see that our people actually enjoy the good health that medical science knows how to provide is one of the great challenges to our democracy.
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> Our objective must be twofold: To make available enough medical services to go around, and to see that everybody has a chance to obtain those services. We cannot attain one part of that objective unless we attain the other as well.

We are confronted immediately by three major problems whenever we consider, as this committee is now, how to improve the health of the American people. All three are problems in economics, not in medicine. First is the problem of manpower and facility shortages; second, the problem of manpower and facility distribution; and, underlying all others, the problem of inadequate medical purchasing power in the hands of a substantial proportion of our families.

These recognizable segments of the total problem are the ones for which all interested groups are seeking solutions. They are closely interrelated. Indeed, it is the position of the administration that the ultimate solution of any one of them depends upon finding answers to all three. That is the firm conviction which underlies the comprehensive national health program recommended by the President as long ago as November 1945, and which underlay Mr. Ewing's report to the

President, the Nation's Health. It also is the fundamental assumption, it seems to me, upon which the program provided in S. 1679 is based.

At this point, let me say just a few words about these three basic problems and their relationships.

First of all, there is the problem presented by the current aggregate shortage of trained health personnel and health facilities: The shortages of doctors, dentists, and nurses, of clinics and hospitals. These deficiencies are very real. They have been extensively documented and there is widespread agreement that they exist. There is less agreement as to why they are so acute and as to the best means of overcoming them. There is, of course, no simple, inclusive explanation. But a major contributing factor is, unquestionably, a serious shortage of medical purchasing power. We do not have more hospitals, for example—even with the expenditure of substantial Federal funds to assist in their construction—because the people in many shortage areas could not support them if they had them.

Secondly, there is the problem presented by the inequitable distribution of the manpower and health facilities we do have. This results in wide discrepancies in the availability of medical care from one section to another, one State to another, and one community to another. Thus, the top one-fourth of our States—the 12 States with the highest ratio of doctors to population—average 1 doctor to every 667 persons. But the 12 poorest States in this respect average only 1 doctor to every 1,223 of their citizens. Consequently, if you are taken ill today in one of the 12 most-favored States, you have about twice as good a chance of getting a doctor when you need him as you do in one of the 12 least-favored States. Contrasts between individual States and communities within States are even sharper. Moreover, the situation is similar in respect to other health personnel, and in the case of the distribution of hospital beds, the discrepancies are even more marked.

The existing distribution is generally unfavorable to the South and West, in comparison with the Northeast, and to rural areas in comparison with urban. But our most serious health problems today—the highest death rates among mothers and children, for instance, the greatest incidence of disease, the most pressing need for medical manpower and facilities of all kinds—these are found in precisely those areas that are so strikingly discriminated against.

The maldistribution of our existing personnel and facilities seriously aggravates the problem of providing adequate medical care to all of our people. And a significant fact in connection with this pattern of distribution is that, in general, it follows closely the pattern of income distribution. By and large, the sections, States and localities with the highest ratio of health personnel and facilities are those with the highest per capita income. Conversely, the most undernourished areas from the standpoint of medical care are as a rule those with the lowest level of purchasing power. This is not, of course, surprising. Hospitals are built where they can be supported, and doctors naturally settle in areas where they can make a living. To me, this means that the key to a more equitable distribution of health facilities is to be sought in some method of increasing the effective health-purchasing power in the medically undernourished areas—a result which is directly accomplished through social insurance.

Thirdly, there is the serious problem presented by the fact that a substantial portion of our people—even those who live in relatively well-supplied areas from a medical standpoint—cannot afford to purchase medical care under a system in which most of the cost of such care falls on the sick. Just what proportion of the population belongs in this category is, perhaps, a matter for honest difference of opinion. The American Medical Association has estimated that no more than 20 percent of our people can meet the cost of a serious illness without assistance in the form of private or public aid. Whatever the number who cannot afford adequate modern care, it is substantial—certainly, at the very least, it includes that half of our population living in families with incomes of $3,000 or less a year. In fact, under the present circumstances, only the relatively rich or the charity poor are in a position to take full advantage of the wonders of modern medicine—the rich at inordinate expense and the poor on terms that are humiliating at best. The great middle-income group—the backbone of the country—are left out in the cold, not wealth enough to meet a sudden emergency or to pay for modern preventive care, but too well-off to qualify and too proud to ask for charity. They can only hope and pray that their own immediate families will be spared a serious and bankrupting illness.

It is of the utmost significance, I believe, that a common financial problem underlies all these others: The current shortage of personnel and facilities; the inequitable distribution of those we have; and the inability of large numbers of our people to utilize them fully. Indeed, in undertaking to improve the Nation's health, we can be fully confident, in my judgment, that the doctors are doing their part of the job magnificently; the results they achieve in those areas where they are given a fair chance are proof of that. The problem now is one for the economist and the statesman.

With this introduction, I should like to turn now to a consideration of what seems to me to be the central issue raised by the three major bills before your committee: That is, the various means by which all of them seek to make medical care available to those who need it. The methods proposed are different and the results would vary widely, but the broad objectives, it seems to me, are similar.

After all, everybody concerned with this problem is interested in the same thing. All want to work out some arrangement to assure the widest possible application of the knowledge and skills our medical profession has developed. All would like to see every American citizen in a position to buy all the medical care he needs, both preventive and curative. It would be good for him, good for the medical profession, and good for the Nation.

Everybody would like to make this possible without resorting to the further extension of State medicine and without restricting the freedom of the patient or the doctor, the hospital or the medical profession as a whole.

As I read these three principal bills, the most significant impression I have is not that they are so widely different, but that they are so much alike. They indicate that a very broad basis of agreement has been reached.

For instance, there is general agreement, with some difference in emphasis, that we do have a serious shortage of medical personnel, facilities, and services—largely as I have outlined it. Moreover, nearly everybody apparently agrees that the Federal Government must contribute, out of general revenues, to the relief of these shortages. Opinions differ as to detail and scope, but not as to principle.

Beyond this, it appears to be agreed that our present system of payment for medical care is totally inadequate. The provisions of all of these bills reflect common recognition of the fact that, as things stand today, a substantial proportion of our population must depend upon public or private charity or go without the type of medical care that modern science knows how to provide.

Most important, perhaps, it seems that almost everybody has now agreed with the conclusion of the National Health Assembly last year, that some sort of health insurance is the only method by which adequate medical care can be made available to most people without expanding State medicine or public charity. Of course, all sorts of problems arise when you examine the details, but there is no doubt that we now have general agreement on this basic point.

As I see it, this represents tremendous progress—far more, perhaps, than the average doctor or patient has been able to discern, struggling as he is to stay afloat in a 3½-million-dollar sea of angry words.

With this broad basis of agreement in mind, I should like to review, as I can see them, some of the underlying realities in this problem of medical care upon which a final solution must be built.

At the outset, however, I want to stress the conviction that unless a comprehensive system of prepayment such as that provided in S. 1679 is established, it will be impossible to meet the Nation's medical needs without an ever-increasing measure of State medicine.

The extent to which Government already is involved in the direct provision of medical care to individuals is often overlooked, I am afraid, in our zeal to identify our system for the care of the sick with our business system of private enterprise. Perhaps it would be more useful to our purpose if we were to face frankly the fact that medical care does not rest upon the same basis at all. Incidentally, I think it would be fairer to private enterprise.

By its very nature medical care is uneconomic. In modern times, it has never rested on the rule of the marketplace, because the public interest has required that illness be treated somehow, whether the individual could afford it or not. But while we never have relied exclusively upon the rule of supply and demand, neither have we worked out a rational and reliable substitute for it which would provide a sound economic basis for our medical system. Instead, medical care has been financed, from the earliest times, in a haphazard way. From the beginning, the economic basis of medicine has been a loosely defined triple standard: First, a rough-and-ready sliding scale of prices for the well-to-do, depending upon how well-to-do and adjusted arbitrarily in individual cases by the physician or the hospital; second, private charity in various forms, both organized and unorganized, for the "medically indigent," meaning those who are self-supporting except in emergency; and, third, Government medicine and various forms of public charity for the poor. It is a makeshift system that "just growed."

In spite of these catch-as-catch-can financial arrangements, the medical profession has made remarkable progress. This is not a tribute to the system of payment, however, but to the devotion of the medical profession and to our national readiness to improvise. In this case, we appear to have improvised ourselves into a situation that almost nobody likes.

Without a workable economic base upon which the private practice of medicine and our voluntary hospital system could improve and expand at a pace consistent with the advance of medical knowledge and general social standards, we have turned over to Government a greater and greater share of responsibility. Almost all of our improvisation, in fact, has been in this direction, until today some 24,000,000 citizens are receiving various kinds and degrees of medical care from the Federal Government alone, according to the Hoover Commission.

It seems to me that this is highly pertinent to the question you are now considering in this committee, since I gather that one of the major objectives of all the sponsors of these measures is to avoid further development in this direction. For this reason, let me review, just briefly, the history of the growth of Government medicine in this country.

Government's role in medicine has increased tremendously in recent years, but its history stretches back beyond the origins of our country. Long before our Constitution was adopted, it was well recognized that the care of the sick could not be left entirely to the operations of supply and demand. True, Government did not intervene except when the public interest required it—whenever and wherever important groups of people could not buy medical care and private charity could not supply it.

A good example was the establishment by the Congress, in 1798, of the first Marine hospital to provide medical care to merchant seamen. This was the beginning of our Public Health Service. Long before this, however—in fact, before the American colonies were founded—the care of the sick poor had been a responsibility of the Government under the Elizabethan poor laws.

The rough rule of thumb would seem to have been that patients with money paid as much as they could or the traffic would bear, private charity did all it was able to do, and Government did for the rest what public opinion demanded. In practice, this resulted in the universal acceptance, for tuberculosis, mental, and other chronic cases, of "State medicine," that is, medical services of all kinds owned and operated directly by Government. It is these cases which account, in the main, for the 3,000,000 admissions to State and local government hospitals last year.

The expansion of Government's responsibility for medical care has been steady and sure through much of our history, but until the comparatively recent past it has been confined for the most part to States, counties, and municipalities. Since the turn of the century, however, the pressure upon Government at all levels to take over a larger and larger share of the load has been increasingly strong. The reason for this is clear.

Fifty years ago, the most expensive and complicated piece of technical equipment in any hospital was the microscope. A number of basic discoveries, such as Harvey's in the circulation of the blood, had been made earlier, but the outward appearance of medical practice had not undergone any marked transformation. Medicine still was characterized by the country doctor's little black bag, and he represented just about all the medical knowledge and skill at society's disposal. But Roentgen, with his discovery of the X-ray in 1895, set off a revolution in medical science and technology. Discovery after discovery followed, each more amazing than the last. Whole new fields of study and investigation were opened up. Medical schools grew, hospitals expanded, and their facilities multiplied in number and complexity. The result was more progress in 50 years than in all the centuries since Hippocrates. But as knowledge increased, as new skills were developed, and new instruments invented, the practice of medicine became not only infinitely more effective, but equally more expensive and beyond the ability of rich men's fees and private charity to support. The people and the profession itself turned more and more to Government.

Today, Government owns and operates three-quarters of all the hospital beds in the United States. Government employs directly thousands of American doctors and pays fees to many more. In Government hospitals and with doctors on the public pay roll in whole or in part, the taxpayers finance full medical care for all members of the armed forces and their dependents and for all veterans with service-connected disabilities; hospital care for all needy veterans and for merchant seamen; and complete care for tubercular, mental, and other chronic patients. Government pays the cost of limited medical care for those on public relief rolls. In addition, the taxpayers carry the full load in that vast field of medical service known as "public health," and provide large sums to support medical research and education.

If you add all this up, you will find that Government today is providing a large share of the total cost of medical care for a substantial proportion of the people, and that it is doing so in very large measure through State medicine, and in the strictest sense of the term. Furthermore, it is evident that the acceleration of this development in recent years has been phenomenal. There is no reason to suppose that it can be halted by any partial or makeshift expedient.

It seems to me that the implications of this are starkly clear. I sincerely believe that we have gone so far along this road, impelled by irresistible circumstance rather than by any design, that the real issue is already quite different than it is usually presented. The real issue as I see it is not between voluntary, private health insurance and a national system based on our social insurance experience, but rather between national health insurance and state medicine. I say this not because I am opposed to voluntary insurance, for I am not, but because I am firmly and honestly convinced that nothing short of the social insurance method can prevent the further—and eventually the complete—substitution of state for private medicine. On the other hand, I believe that social insurance can prevent it, because it would establish exactly the thing that has always been lacking and which has rendered private medicine incapable of doing the full job. That is, a sound, firm, reliable economic foundation upon which private medicine can expand and flourish.

Let me repeat and reemphasize that I am not in any sense opposed to voluntary health insurance. I, personally, have been a subscriber for a long while. Furthermore, I was a vocal supporter of it long ago, when the American Medical Association, which so recently became its ardent advocate, was denouncing it as "socialism and communism, inciting to revolution." I simply am convinced that voluntary health insurance cannot do the job which all of us agree must now be done. The situation has changed radically since the AMA took its original stand. Voluntary insurance has not exactly led to revolution, but neither has it halted the trend toward state medicine. On the contrary, no period in history has seen such rapid development in that direction.

One difficulty with voluntary health insurance is that it costs too much for most people to buy, and it cannot pay its own way on lower premiums. Since the AMA's recent conversion, we are told that health insurance has made gigantic strides and now affords protection to 52,000,000 Americans, or one-third of the Nation. This may be true. But the question arises, "What are they protected against?" And the answer is that less than two-and-a-half percent have anything even approaching the comprehensive protection that is provided for in S. 1679. Other voluntary insurance subscribers have protection ranging from next to nothing under policies with a great deal of fine print, to limited protection under several different policies for hospital, surgical, and medical care. The cost is in proportion to protection, and it is not cheap; if it were, far more than a third of the people might be expected to buy such little packages.

Another pertinent question would be, "Who is protected under voluntary insurance?" As with the distribution of medical personnel and facilities, so it is with voluntary insurance policies; you find them where the money is, not where the need is greatest. Most voluntary insurance policies are issued by Blue Cross Hospitalization Plans—the AMA says 32,000,000 of them—providing limited insurance for hospital care only. About 60 percent of these policies are held by citizens of six rich industrial States which contain about 36 percent of the total population of the United States. Only about 17 percent of Blue Cross members live in Southern and Western States with 43 percent of the population. Less than 3 percent of the rural population belong.

Even granting the validity of the AMA's own figures, which have not been noted for objectivity in this regard, two-thirds of our people have no protection of any kind under voluntary insurance. And this after 20 years of intensive advertising and selling.

It may be that by helping to defray the administrative costs out of taxes, by subsidizing the coverage of those who cannot or will not pay the premiums, and by appropriating public funds for a high-pressure advertising campaign, it would be possible to bring most of the population eventually into these privately controlled plans. This, of course, would achieve the same result as social insurance, but it would be infinitely more costly and would raise serious questions of public policy. Anything short of this, however, would fail to meet the problem and probably would lead only to greater acceleration of the trend toward state medicine.

On this score, I agree with the conclusion that was reached years ago by the American Medical Association, that, if we are going to adopt any form of health insurance, we should go all the way and embrace compulsory national health insurance. They contended then, as we do now, that experience in other countries had proved that voluntary insurance was totally inadequate and could not be otherwise.

All the history of health insurance proves, it seems to me, that if one of our objectives is the prevention of State medicine, then we ought to be extremely wary of proposals that we merely go wading in health insurance now. For if experience has shown anything, it is that the stream is deep and you either swim or else. With all respect, for I know the sponsors have worked devotedly and hard to solve a complex problem, this is our chief objection to S. 1456 and S. 1581—that they invite us to go wading in a stream where one must swim or sink. S. 1769, on the other hand, not only invites us to swim, but provides a set of water wings as well.

I have read these bills carefully and cannot escape the conclusion that S. 1456 and S. 1581 do not, in the last analysis, place very much faith in voluntary insurance. Instead, it appears to me that both of them, while one requires and the other permits the use of voluntary plans' administrative machinery, rely in effect if not in purpose upon public charity—a medical dole. Moreover, both are so limited in scope that I am afraid that whatever beneficial effect they might have would serve merely to intensify the dissatisfaction of those who would be excluded from their benefits.

Let me illustrate these points by reference to S. 1456, since it is the more specific of the two and since it bears the title, Voluntary Health Insurance Act. Also, this bill has been widely publicized as a measure which would solve this problem by the use of voluntary insurance.

Leaving out all of the provisions for State plans, and so forth, which are familiar devices used in the various grant-in-aid programs, it provides for the appropriation of an unspecified amount of money, to be matched by the States. The State, either before or after a person becomes ill, is to give the individual a card which will entitle him to get medical and hospital care—apparently about the same extent of service he would get if he belonged to the combined Blue Cross-Blue Shield plans today. At the outset, this would be far less protection than he would get under S. 1679. In S. 1581, an even more stringent limitation is applied through an appropriation-authorization ceiling.

To begin with, is this insurance at all, voluntary or otherwise? Of course, if the recipient were to get his card even a few days in advance of illness, presumably he could, if he chose, look upon it as insurance without premiums. But as far as the State is concerned, it would merely be a requisition upon the insurance plan for the purchase, through it, of whatever medical and hospital care the holder might need, within the limitations. The bill provides that payment by the State to the insurance plan must cover the full cost of whatever care the plan purchases for the holder of the card, plus the plan's administrative expenses. If this interpretation is correct, then the taxpayer, at least, must look upon it, not as insurance in any sense, but as direct relief to the recipient. On that basis, it might be open to question whether the insurance plan contributes anything essential, or whether the State itself might not handle the administration more economically without the middleman.

This might be even more pertinent if, as some opinion holds, the bill would make possible the payment of these public funds for the purchase of medical care through commercial, profit-making insurance companies as well as the voluntary nonprofit plans. This question arises particularly in connection with the Blue Shield plans. In some States, about six, I believe, the only service they provide is to endorse and recommend commercial insurance policies. Could money, under S. 1456, be paid to these Blue Shield plans, to be paid by them in turn to commercial insurance companies, to be used by them in turn for the purchase of medical and hospital care for the holder of the card? I feel sure that this is not intended, but the question has been raised, and I cannot tell by reading the bill whether the answer is "Yes" or "No." If the answer were "Yes," then it would be pertinent to point out that in some cases, as much as 70 percent of the subscriber's payments to commercial plans go for overhead expense.

But these are details. Whether the card the recipient holds is insurance or merely a promise that the Government will pay for his medical care, within limits, the next question is, how many will get such cards?

To start with, the only ones we can be sure of are those "on relief" and those receiving unemployment compensation. These can be certified with no further investigation as being unable to pay all or part of the cost of premiums—a process which the bill requires. The rest is uncertain. It may be that some simple method of certification is contemplated but not written into the bill, even though this presumably would open the door to a great deal of waste and inequity. However, if the State is to follow the procedures worked out over the years for such purposes, then certification of those not already on the rolls as indigent will be unavoidably costly and time-consuming.

Senator TAFT. What does your plan do for people who have no money? How do you take care of them?

Mr. KINGSLEY. As I would read S. 1679 provision is made for direct service by the State to people who are on the rolls, Senator Taft. Anybody who is not on the roll is not covered. And this question does not arise under S. 1679 as I would read it.

Senator TAFT. They do not cover people who are not enrolled at all, do not take care of the indigent and the poor at all you mean?

Mr. KINGSLEY. The people on the indigent and relief rolls, and therefore already identified by the State, would be taken care of, as I would read S. 1679. But the problem that arises here is one of interpretation. It may be that under these bills only the people on the relief rolls already are to be taken care of.

Senator TAFT. They have to pay hospitals or doctors or somebody to take care of them just as Mr. Hill's bill provides for taking care of them by private insurance funds if necessary.

Mr. KINGSLEY. Yes, sir.

The question that I am raising here—and perhaps I am not stating it very clearly—is one of administrative difficulty. It would seem to me, that is, from reading these bills, particularly Mr. Hill's bill, there are two possible interpretations. One is that it is restricted to people already on the relief rolls, already identifiable in the State, and in that event, as I will indicate shortly, it seems to me that taking care of them can be best done by an amendment to the Public Assistance Title of the Social Security Act which has already been recommended by the administration and has been considered by the House Ways and Means Committee, and ultimately will be considered by the Senate Finance Committee.

Senator Taft. In one way or another you give free medical care to the people who cannot pay for it under any of the bills?

Mr. Kingsley. Yes, sir.

Senator Taft. And whether you give it by insurance fund or a private hospital or a city hospital, I do not quite see the difference in administration. The principle is the same.

Mr. Kingsley. I agree there is no difference in principle. The question I am raising here, the point I am attempting to develop, and perhaps which has not been done very clearly, is that if Senator Hill's bill is restricted to people on the relief rolls already, then our position would be that that could be most easily handled without the intervention of voluntary insurance systems or anything else except an amendment to the Social Security Act.

Senator Taft. You cannot give them medical care by an amendment. Somebody has to give it to them, hospitals or doctors or somebody.

Mr. Kingsley. Yes.

Senator Taft. Whether it is by private insurance fund, or private hospital, or public hospital. I do not quite see the point. They would have to take care of the poor and the indigent and the people who do not pay a tax under the insurance fund.

Mr. Kingsley. Except, as I am sure you know, Senator Taft, most of the existing voluntary plans are not service plans. They do not provide anything in the way of service. They just collect money. They are just financial channels.

Senator Taft. That is right, and that is what you are proposing the Government be. However, go ahead. I do not want to interrupt your general statement.

Mr. Kingsley. Perhaps we can come back to this if my point does not emerge out of this.

Senator Taft. Yes.

Mr. Kingsley. The next line is on the assumption that perhaps the people who are eligible under this bill are not those merely restricted to relief rolls.

Beyond this, what is to be the basis for the distribution of "insurance" cards to those not already certified as indigent? Presumably, everyone else is self-supporting or has been too proud to ask for charity. Is the State to seek them out and urge them to get on the rolls, to sign up as partial charity cases and accept "voluntary insurance" cards? What would be the advantage to the individual? He has exactly the same assurance of aid if he waits until he gets sick, and meanwhile he can at least nurse the hope that he will be a lucky one and will not have to admit his dependence.

For that matter, what is the advantage to the State? Why should the State go out of its way to sign up recipients in advance, since the requirement in any case is to pay the full cost of medical and hospital services provided, plus the insurance plan's administrative expense? Since the State is to give this guaranty, is the same guaranty to apply in reverse? If not, the advantage would seem to be one-sided. And in that case, I would be impelled to ask this further question: What rates are going to be charged? It is well known that people in the lower-income brackets are looked upon by the insurance experts as bad risks, and therefore chargeable at a much higher rate than is carried by most of the policies now in effect.

Indeed, this is one additional reason why the voluntary plans have never reached down below the upper one-third of the population.

After careful study of these bills, it seems to me that either S. 1456 or S. 1581, if adopted, would confront the Nation with a most unpalatable dilemma.

They could be interpreted and applied in either of two ways: to make medical care on a limited basis available only to those already on relief, or to lift the ceiling on pauperism and include the medically indigent as well.

If the first interpretation is intended, then these bills would not do more than the administration has proposed we should do for the indigent, in its recommendations for the expansion of medical care under the public-assistance title of the Social Security Act. Exhaustive hearings on these proposals were completed only recently by the House Committee on Ways and Means, and presumably they will be studied soon by the Senate Committee on Finance. After comparing the provisions of H. R. 2892 with those of S. 1456 and S. 1581, I believe you will agree that, if we are considering only the indigent, the problem can be met far more economically and effectively under the program already established.

If, on the other hand, the ceiling is to be raised to include the medically indigent in a program of public charity—and this seems to me to be the more likely interpretation—then we come face to face with a number of serious questions:

1. Is it good public policy to encourage normally self-supporting citizens to seek charity?

2. Would it be possible, without such encouragement and without in some way removing the onus which attaches to the means test, to bring into such a scheme any significant number of persons who are now too proud and self-reliant to ask for charity? I assume that this is the purpose of those provisions which would permit the use of public money to advertise private voluntary insurance plans and their availability at public expense.

3. If such a scheme were successful in providing coverage on an adequate basis for all those who need it, would not the cost be even greater than the cost of national health insurance as provided in S. 1679?

I have nothing but admiration for the many men who have sought so diligently to work out a substitute for national health insurance. But I am convinced that no amount of ingenuity can make these schemes effective except in the swifter realization of the very result their sponsors seek most to avoid.

Senator TAFT. This provision in your bill, on page 111, section 705, provides that the State may contract with the Federal Government to give these services just as Mr. Hill's bill provides they may contract with private insurance funds.

Mr. KINGSLEY. As this bill is written, as I understand it, Senator, in effect you have a contractual arrangement between the Federal Government and the State for all provisions.

Senator TAFT. It provides for the State care of the indigent, and a contract with the Federal Government, and to pay the premium to them. I do not see how that is a different principle from Mr. Hill's bill, which provides an insurance fund—the State goes to them and lets them provide the care to the indigent. I do not quite see the difference in the principle you are trying to make in this whole discussion when it comes to dealing with the strictly indigent. I am not speaking about the intermediate group.

Mr. KINGSLEY. First of all, I should say, in respect to that, Senator Taft, that this is not in every aspect, every detail, our bill. This is a bill which was prepared by the sponsors to meet the broad provisions of the President's program.

Senator TAFT. You are speaking of S. 1679 now?

Mr. KINGSLEY. Yes; S. 1679.

Senator TAFT. Will you tell us then, later, how you would change it? In what respect do you disagree with it?

Mr. KINGSLEY. On this particular point, it would certainly be our position that if the Administration's recommended amendment to the Social Security Act is adopted by the Congress, which, in effect, provides for payments by the Federal Government to the States on behalf of medical expenditures for the indigent in the State, then there would be no need for this particular section in S. 1679, and that that would be, from our point of view, a more direct method of approaching this.

S. 1679, on the other hand, offers a real and lasting solution to all of the major problems I outlined at the opening of this discussion. First, it takes full cognizance of the shortages which exist today in medical manpower and facilities, the extent and seriousness of which are known, and makes provision for Federal assistance to the States on a scale sufficient to meet them. This will help to wipe out the great accumulated deficit of supply which has resulted inevitably from the inability of our people to buy the medical care they should have.

As I suggested, however, the finest medical service is of little value, no matter where or in what amount, unless it can be maintained economically. Title VII of S. 1679 deals with this problem in the only effective way I know, by applying the method of social insurance which we have tried and tested for more than a dozen years.

Senator TAFT. In which field do you mean, old-age pension?

Mr. KINGSLEY. Yes, sir; primarily in connection with old-age and survivors insurance.

Senator TAFT. It has not been notoriously successful, however, I would think, when you now need a complete change in the whole system.

Mr. KINGSLEY. I would say it has not kept pace, the system has not kept pace with the changes in the price level, and the coverage has not been extended to the extent we would have hoped and that S. 1679 provides. S. 1679 provides very broad coverage.

Senator TAFT. Not only that, but it provides less income than noncontributors get in many States already.

Mr. KINGSLEY. That is right.

Senator TAFT. That is not a very good thing on which to base an argument that the principle should be extended.

Mr. KINGSLEY. That would seem to me to be because the Congress by and large had chosen to raise public assistance benefits rather than to raise the insurance benefits. But in terms of the system I think there is no reason at all why the insurance-system benefits could not have been raised to keep pace with changes in the price level, and the administration has recommended that.

Senator TAFT. It was purportedly a system of insurance, and it is supposed to pay for itself, and as a system of insurance it has not and will not. Therefore, I do not see that it is any argument for insurance. That is the point I make. The reason it has not been changed, it was supposed to have been an insurance operation, whereas direct aid varies according to need. Now you propose to throw away the actuarial system and change the whole thing.

Mr. KINGSLEY. I would not see it that way, Senator Taft, because our proposals are also for raising the base, as you know, from $3,600 to $4,800, so at the same time the benefits are raised there is an increase in return in premium and return to the system, again based upon changes in wage and price levels. So I think the principle is maintained in the administration's proposals.

Senator TAFT. You said "by applying the method of social insurance which we have tried and tested for more than a dozen years." It did not seem to me that, as an example to be followed, it is particularly justified by our experiences .

Mr. KINGSLEY. We have a difference of opinion on that point.

By this method, it would establish a firm, dependable economic foundation under the whole structure of private medical practice. It would result in the establishment and the effective maintenance of doctors, hospitals, and all other health personnel and facilities wherever they were justified by the number, not the wealth, of prospective patients. For the first time, it would make it economically worth while for doctors to use their talents where they are most urgently needed. No longer would the doctor be forced to hold a stethoscope upon the patient's heart and pocketbook at the same time, and adjust his fees accordingly. No longer would he feel compelled to reserve the prescription of expensive treatments and drugs, regardless of their effectiveness, to those whose wealth permits their use. Instead, he would be completely free, for the first time, to consider each patient solely on the basis of professional judgment and not with the appraisal of a bill collector.

As for the patient, no longer would he be compelled to consider the cost of illness first and its consequences later. No longer would he feel hesitant, for fear of the cost, about going to the doctor at the first sign of illness, and thereby reaping the incalculable benefits of modern preventive medicine.

It is hardly necessary for me, Mr. Chairman, to picture for you all the endless chain of beneficial results which would flow automatically from the mere fact that, upon the enactment of this bill, almost all of the people in the United States would have the purchasing power with which to buy all the medical care they need.

But still there are those who fear this program, who contend that it would regiment the doctor, interfere with the freedom of the patient, destroy the standards of medical care, and lead to socialism.

I subject that these are fearful phantoms, and that not a single one of them could possibly materialize under the terms of this bill. These terms are explicit and plain. Its administrative provisions guarantee the widest decentralization of authority, with full representation of both doctors and laymen. They assure that the most important decisions affecting doctors and patients will be determined by their own local representatives, in their own communities. And to make the assurance doubly binding, the bill specifically spells out and guarantees all the freedoms which we are told it would take away.

It seems plain to me that only by this method of social insurance can we effectively shore up our voluntary hospitals and our system of private medical practice, and forestall the need for a further extension of state medicine. We are moving fast in that direction, and I sincerely hope that the President's program will not be delayed too long.

That concludes my formal statement, Mr. Chairman.

Senator MURRAY. Any further questions, Senator Taft?

Senator TAFT. Yes. Senator Hill, do you want to go ahead?

Senator HILL. I am not a member of the subcommittee, you go ahead.

Senator TAFT. Mr. Kingsley, I have not interrupted you, but I do not want my silence to indicate my agreement even with some of your conclusions about our bills, or with some of the general statements.

You say:

> It appears to be agreed, for instance, that our present system of payment for medical care is totally inadequate.

I do not agree to that at all, and other things. But there is no use in getting into an argument on the general principles of the two bills. I simply want to say that I disagree with the conclusions you make in respect to a dozen different things in the statement.

I would like, if it is in order, Mr. Chairman, to ask Mr. Kingsley about this bill.

My theory of this opening statement was that the advocate of each bill, with some assistance, was to present, so to speak, the case for his bill and explain what it was. I would like to find out exactly what S. 1679 does if that is in order at this time, Mr. Chairman.

My own ideas of it have changed from time to time on the general plan, and if it is in order I would like to ask those various questions as to what the Federal Security Administration has done in preparing these provisions.

Senator MURRAY. I see no objection to proceeding along that line.

Senator TAFT. I do not want him to be elaborate. He can answer in detail later. I want to get a general picture of what the bill does.

First is title I, Education of Health Personnel. What has the Federal Security Administration done about consulting with the various medical schools, and what recommendations have they from the medical schools or public-health schools, and so forth. And exactly what is the provision that you are contemplating in this bill? I notice it covers nearly 70 pages.

Mr. KINGSLEY. Shall I proceed?

Senator TAFT. Yes. I think I certainly agree with your general statement that there are not enough doctors. I think that is fairly well agreed to by nearly all the doctors and everybody else. It is a concern that we should not expand the thing too rapidly, that we should not let the medical education fall off in quality. But I think there is a general agreement on the need for doctors. I have been puzzled about the best course of trying to provide them.

Mr. KINGSLEY. We have been, too, Senator Taft. You will recall that last year Senator Thomas put in a bill on this subject which differs substantially from the provisions in title I of S. 1679. This current bill differs from that in large measure because of the number of consultations we have had with representatives of the medical schools and with the university presidents. In fact, the university presidents and the deans of medical schools have taken somewhat different positions as to the best approach to the problem.

Senator TAFT. Yes. I have talked to a great many of them, and I have found many differences of opinion. That is the reason I want to raise this question. You notice in our bill, while we did provide some temporary things for doctors only, we provided for setting up a commission to try to study the problem. I wondered what you had already done in that respect.

Mr. KINGSLEY. The medical deans set up a committee, or, perhaps, we set it up in consultation with some of their leaders. I think there was quite a large group, about 30 medical deans, who met with us on several occasions and canvassed this situation. And we have also, as I indicted, met on two or three occasions with representatives of the university presidents.

The major request, I would say, from both the presidents and the deans was for Federal assistance in maintenance and operation, and Federal assistance for construction. There was no great enthusiasm, I would say, on the part of either group for an incentive system which would require them to expand their enrollment, although that, in fact, is, of course, what we are primarily interested in.

The presidents, I think, are more inclined toward that. In fact, President Conant recommended to us a differential. You have the same idea in your bill, $500 for existing enrollment, and $750——

Senator TAFT. Yes. Do you think you can get much increased enrollment by that? The limit seems to be on facilities and teachers rather than on the willingness to take people.

Mr. KINGSLEY. It is a very complex situation, Senator, and the particular bottleneck in any given school may not be the one that exists in some other schools. Some places it is hospital beds, and some places they need a teaching hospital. Some places it is the laboratory facilities, and in some instances it is a matter of the university budget which, in turn, is a matter of assistance for maintenance, because every time they take a few more medical students it causes a big drain on the total budget of the university since this is the most expensive of all schools in the university. So the situation we discovered seemed to be a very complicated one needing a sort of multilateral kind of approach, which is provided in this particular title. There are, as you know, provisions here for grants for maintenance and operation.

Senator TAFT. First, you have grants direct to the school, so much per student.

Mr. KINGSLEY. Yes.

Senator TAFT. Three hundred dollars per student, and $1,700 for every student over the average in recent years, whatever the formula may be.

Mr. KINGSLEY. Yes. That $1,700 figure was arrived at by taking the average cost of medical education and the average tuition paid and subtracting the tuition from the cost. It cost the average university about $1,750 to educate each medical student.

Senator TAFT. Are there any grants to medical schools—I leave out for the moment the other schools, nurses, and so forth, which follow the same general principle.

Mr. **Kingsley**. Yes.

Senator **Taft**. Is there any provision for grants to medical schools to increase facilities, buildings, equipment, and so forth?

Mr. **Kingsley**. Yes, sir; there are provisions as far as construction is concerned for both loans and grants, and for both construction and equipment, in section 373. There is a provision for an unspecified amount. It is a matter of appropriation-authorization in general terms for these purposes.

Senator **Taft**. Who distributes that? That always worries me when you get a Federal thing like that, every State wants a new medical school whether they are able to handle it or not.

Mr. **Kingsley**. As I would read this it would be distributed directly to the schools by the Surgeon General. And there is only a broad general guide as to how he would distribute it.

Senator **Taft**. It is in his discretion entirely?

Mr. **Kingsley**. At his discretion except grants are to be made in the order of significance of their effect in alleviating shortages.

Senator **Taft**. And he determines that?

Mr. **Kingsley**. Yes, sir; it is very broad—up to 50 percent of cost of the project.

Senator **Taft**. Can he set up new medical schools under that authority?

Mr. **Kingsley**. Yes; it would be both.

Senator **Taft**. It seems to me that I remember Dr. Parran's policy in the expansion of medical schools related to the gradual addition of a certain number of medical schools to the total rather than the expansion of existing schools. Am I correct in that or not?

Mr. **Kingsley**. I am not certain, Senator, on that. I think that is right. I think originally the position was support for creation of new schools .

Senator **Taft**. My recollection was that he figured it would take 10 years to get to the point that he thought you ought to reach, that you could not do the thing overnight.

Mr. **Kingsley**. I think that is about what our estimates are today.

Senator **Taft**. Have you any estimate on the cost of these two items, $300 and $1,700?

Mr. **Kingsley**. The Public Health Service at the moment is making a survey on need for construction among medical schools. Whether they have advanced far enough yet to give a figure, I do not know. I can supply that for the record if they have.

Senator **Taft**. You can do that later in your detailed discussion on the subject, which comes about in 3 weeks, I think.

Was there also included here a provision for scholarships direct to students?

Mr. **Kingsley**. Yes, sir; there is a provision for scholarships and for the payment of maintenace costs to medical students; maintenance allowances to medical students varied in terms of dependents in addition to a tuition payment for fees and books. That is in section 377 and section 378.

Senator **Taft**. Is there any particular immediate need for that? There may be in time to come, but is there any immediate need for that in view of the tremendous number, four or five times as many, people applying for medical schools than they can take in?

Mr. Kingsley. I would say in viewing the problem merely from the standpoint of expanding the number of trained personnel, that at the moment there is not a need for it. On the other hand, in terms of providing, of getting the best trained personnel, there is need for it. But it is a different kind of emergency, a different kind of a problem rather than a shortage problem.

Senator Taft. I notice the Gallop poll showing 28 percent of all families wanted their sons to be doctors compared to 14 for engineers, and then about 9 or 10 for lawyers and business executives.

Mr. Kingsley. I saw that same poll.

Senator Taft. There seems to be a great urge for medical education.

Mr. Kingsley. The situation in that respect, Senator, I think is different, perhaps, in connection with dentists, where a very large proportion of the dental students at present are under the GI bill, and where they have some concern as to whether they will keep up their enrollments as the GI benefits fall off, and the situation with respect to nurses where there is a real need to increase the allowances apparently for student nurses in order to recruit people into that.

Senator Taft. To get enough?

Mr. Kingsley. Yes. It is quite different from the doctor situation.

Senator Taft. What is this long section on practical nurse training?

Mr. Kingsley. That provides for training in the States through the vocational education agency, and at the Federal level through the Office of Education, of practical nurses who are not fully qualified nurses. They are at a lower level of occupation, as you know, in terms of specialization than a fully qualified registered nurse. But they will help to fill the gap between supply and demand for nurses at the present time or for the foreseeable future.

Senator Taft. It is a shorter course?

Mr. Kingsley. A much shorter course. There are programs, as I understand, in a number of States at the present time. I am not entirely familiar with that.

Senator Taft. Isn't there $15,000,000 a year?

Mr. Kingsley. I believe there is a specific authorization.

Senator Taft. Page 36, $15,000,000 a year.

Mr. Kingsley. Yes; $15,000,000.

Senator Taft. That is, you feel there is permanently in the Nation a need for two classes of nurses, one of trained nurses and one practical nurses, is that it?

Mr. Kingsley. In general, my feeling is that one of the problems in terms of shortages that we face is a tendency toward overspecialization, toward more training than is needed for a particular kind of job. If we can get what we used to call during the war a job dilution approach, less highly trained people could do a number of these things, and that would help greatly to solve the whole problem and to reduce the cost of medical care, too.

Senator Murray. In dentistry that system is applied?

Mr. Kingsley. With dental technicians.

Senator Murray. And that enables them to do a great deal more work by having someone who is not a dentist but who has ability to do some work?

Mr. KINGSLEY. That is right.

Senator MURRAY. Could these practical nurses continue their studies or training so as to finally become trained nurses?

Mr. KINGSLEY. I believe so. Yes; I would see no reason why they could not.

Senator TAFT. We had the hearing the other day on public-health units. Are these practical nurses capable of being nurses for public-health units?

Mr. KINGSLEY. Yes; they are capable of performing a very large part of the duties that comes under public health.

Senator TAFT. I think it was claimed that a properly equipped public-health unit to deal with 50,000 people would require 10 nurses. Could those all be practical nurses or would some have to be regular nurses and some practical?

Mr. KINGSLEY. My impression is that you would have to have some registered nurses.

Senator TAFT. Title II deals with medical research. This whole field of medical research is being dealt with in detail and in general, and the basic research, we were told, is supposed to be in the National Scientific Foundation's work. Do you need any additional treatment here, or what is the purpose of putting it in this bill?

Mr. KINGSLEY. Well, there are two very important points from our standpoint in this particular title. As you indicate, the tendency of the Congress has been to set up a whole series of categories of research institutes under the national institutes of health. And in each session of Congress there is a tendency to set up new ones, and it is very difficult to develop a coordinated, balanced research program under that kind of an approach, because obviously the number of categories could be multiplied almost indefinitely.

Now this provision, among other things, provides, or authorizes the Surgeon General, with the approval of the Administrator, in part (d) on page 32, section 202, to create additional institutes, and it also permits him, I believe,— or it may be that we have recommended it should permit him to abolish institutes when enough emphasis has been given to that particular point. So our interest in this bill primarily would be to add flexibility to the existing program.

Senator TAFT. Does it include the right to grant money to private institutions, I mean nonprofit institutions?

Mr. KINGSLEY. Yes, sir; this would not change the existing authority in that respect under the national institutes of health, and those grants are for the most part direct to institutions or individuals.

Senator TAFT. The effect of this title would be to transfer the whole control, so to speak, of this kind of thing to the Appropriations Committee.

Mr. KINGSLEY. It might have that effect; yes, sir.

Senator TAFT. They would probably insist on detailed programs there before they granted any money, I assume.

Mr. KINGSLEY. We would hope that would not, but in terms of the history of the thing so far, I think that would be, perhaps, a pretty good guess.

Senator TAFT. You mean you would like them to give you a lump sum.

Mr. KINGSLEY. Well, in terms of the development of research programs involving scientific judgment, it seems to us preferable to have a good deal of leeway in the Surgeon General and the directors of the National Institute of Health as to just what diseases are going to be given particular emphasis at a given time, but I think the point is probably well taken that the tendency of the Appropriations Committee would be clearly, particularly in view of the great public interest in the specific ailments and diseases, to write in specific restrictions.

Senator TAFT. What do you conceive to be the connection of the National Research Foundation set-up, the bill the Senate passed and is now in the House, between that and the Surgeon General's activities? Would they be coordinated?

Mr. KINGSLEY. Well, that, Senator, has given me a good deal of concern, not only in terms of relations with the Surgeon General, but more broadly than that because I was the executive secretary of the present Scientific Research Board a few years back, and we surveyed the whole Federal research effort, and it seems to me although there is no assurance in terms of the way the bill is now drafted, that the National Science Foundation should be a capstone to this whole business, and should fill in gaps and attempt to coordinate and do a balancing kind of job in the fields of basic research. It canont go into applied research, and a good deal of research of the National Institute of Health is what I would call applied research.

Senator TAFT. The attempt to find the cause of cancer is all basic research?

Mr. KINGSLEY. It is basic, there is no question about that at all, but when you get into the basic part of the research it does not make much difference whether you are working on cancer or something else. Because it is basic it is the kind of thing that cuts across the board and involves a lot of things about cell growth or disease.

Senator TAFT. Is this title II in a separate bill, also, Senator Murray? Did you not have hearings on a bill on some of these special diseases?

Senator MURRAY. We have a number of separate bills here on cerebral palsy, multiple sclerosis, rheumatism, and epilepsy. They are separate bills and we held hearings on them.

Senator PEPPER. Leprosy, also.

Senator TAFT. Did you also consider a possibility of reporting out something like title II separate, perhaps, in lieu of a lot of new institutes?

Senator MURRAY. Yes, to have them all in one group, and I think that those who are advocating the bills would get together and agree on some such program as that. It would make it less expensive to operate than if you had a separate institution for each one because the specialists or experts on one disease would be available for work in the other diseases.

They are all men trained along the lines that would make them available for almost any kind of a study, any kind of research.

Senator PEPPER. Excuse me, if you will allow me to interrupt. I wish to make this statement. Mr. Kingsley, at the present time neither the Surgeon General nor the Federal Security Administrator has the authority to set up a new institute as such; does it?

Mr. KINGSLEY. No; that is correct, Senator.

Senator PEPPER. They do have authority to carry on general research.

Mr. KINGSLEY. That is right.

Senator PEPPER. But heretofore we have been proceeding on the assumption that it required statutory authority to set up an institute. Now I think what was basically behind these various measures, we are just coming to an awareness of many other things that need to be the subject of special study in addition to the few that already are embodied in the institutes that exist, and I think the idea was to authorize an administrative set-up of various institutes when funds were available, and they felt ready to move into that field without, perhaps, Congress having to pass a separate bill on each subject from time to time. Was that not what was basically behind this?

Mr. KINGSLEY. Yes, Senator Pepper; that is what I would understand, plus the fact that there would be greater administrative flexibility in terms of how the research program was laid out.

Senator PEPPER. That is true.

Mr. KINGSLEY. And what attack you make on particular diseases under this title.

Senator PEPPER. At the present time will you enumerate the institutes we now have?

Mr. KINGSLEY. We have the National Cancer Institute, Heart Institute, Mental Health Institute, and Dental Institute.

Senator PEPPER. Those are the four?

Mr. KINGSLEY. Yes, sir.

Senator PEPPER. Those are the four institutes that exist at the present time.

Mr. KINGSLEY. Yes, sir.

Senator TAFT. Is there some special provision here about the payment of salaries to 30 specially qualified workers?

Mr. KINGSLEY. In the research title? Frankly, I do not recall any such provision.

Senator TAFT. Page 47.

Mr. KINGSLEY. Oh, I am sorry, but I do recall that now. Yes, there is. It is similar, as I understand it, to legislation which has already been adopted for the National Defense Establishment, and which permits them to select a specified number of highly qualified persons and pay them above the civil-service ceiling. This would do the same thing for the National Institutes of Health.

Senator TAFT. That is, to pay not less than $10,000 or more than $15,000 per annum?

Mr. KINGSLEY. Yes, sir; for no more than 30 positions.

Senator TAFT. Those people would be technically trained, would be supposedly technically trained scientists.

Mr. KINGSLEY. They would be outstanding scientists, sir.

Senator TAFT. That is not for administrative purposes?

Mr. KINGSLEY. No, sir.

Senator TAFT. Title III is the hospital survey and construction amendments. Is that more or less the same as the bill that Senator Hill's committee has considered?

Mr. KINGSLEY. I believe this identical or substantially the same in any event.

Senator TAFT. We do not have it here before this committee at this time?

Senator MURRAY. No, that is being heard by a separate subcommittee.

Mr. **Kingsley**. In general what it does is to double the amount per year, raise the amount from seventy-five to one hundred fifty thousand dollars of Federal money per year and to extend the program beyond the 5-year limitation.

Senator **Taft**. We have already recommended that bill, have we not, Senator Hill?

Senator **Hill**. No, we have not. We have concluded the hearings on it, but we have not been in executive session on it yet. We hope to go into executive session this week.

Senator **Taft**. It will probably be dealt with separately then at least by reporting out a separate bill on the subject.

Senator **Hill**. That is right.

Senator **Pepper**. Will you allow me to interrupt right there? Title III, I believe, however, does embody the Holland-Pepper amendment that we offered to the Hill bill in making it retroactive, that is a formula that is presently embodied in the Hill bill retroactive to the beginning of the program.

Senator **Hill**. That is right, and the Pepper-Holland amendment is before our subcommittee in connection with the bills that we have there. That is correct.

Senator **Taft**. Title IV, Special Aid for Rural and Other Shortage Areas. Will you explain what the proposal is to meet that?

Mr. **Kingsley**. Well, this title is devised to meet as rapidly as possible, to overcome as rapidly as possible, the more striking discrepancies in the availability of facilities and personnel as between different sections of the country, particularly rural areas as compared to urban, and it has a number of separate provisions under section 402.

First of all it provides for grants, Federal grants, which might be used to guarantee minimum incomes or to guarantee operating expenses to people who will go to the shortage areas, for grants to cover their transportation and that of their families and of household goods, and for grants to subsidize the beginnings of group practice operations. So much for the grants.

It also provides for loans for the cost of facilities, and it provides for grants and loans for the construction and equipment of health centers and clinics and so on.

Senator **Taft**. Why is that not covered by the hospital bill as far as health clinics are concerned?

Mr. **Kingsley**. Well, we have raised a point in that respect in our report on this bill, Senator Taft. There is a problem in respect to gearing this into the hospital construction program. There is a provision in here that that shall be done. I cannot put my finger on it right at this moment. Oh, yes; section 403:

> (a) In establishing policies governing the making of grants and loans under subparagraph (1) (d) of section 402 (a) National Health Insurance Board shall take into consideration the State construction programs and the policies and requirements (including the applicable limitation on the amount of Federal grants) contained in or established under title VI of the Public Health Service Act.

Presumably this activity, which would be a special activity engaged in by the National Health Insurance Board is a part of the make-ready effort to get ready for full service under health insurance, would be engaged in full light of the State plans under the Hospital

Construction Act. But there is a problem there; there is no question about it.

Senator TAFT. We do have the general question, I know, of doctors not going naturally to areas where they cannot earn a living. In our bill we have simply provided that in a general State plan the State may use Federal money to provide inducements to physicians and dentists to practice in areas which, without such inducements, would be unable to attract needed physicians or dentists, leaving it to the States to determine the exact method in which that money might be used in the plans that they submit to the Surgeon General.

It seems to me this is a rather elaborate plan for grants and loans to all sorts of different people. They are rather confused with the hospital plan.

Mr. KINGSLEY. I might say with respect to your first point, Senator Taft, that this bill also provides in title VII in having provisions for State plans, for the State to submit plans to do exactly the same thing, once they get in operation, so I would read this as being a title which would be mainly applicable in the period before the health-insurance system is in full operation, although it could be used at any time to help equalize differences from one section to another.

Senator TAFT. This assistance to farmers' experimental health cooperatives, where does that come from? Is that your development or did farm organizations suggest it, or what?

Mr. KINGSLEY. No, sir; I believe that was worked out by the sponsors. They will have to speak for themselves. I am not certain with whom they worked.

We have one or two questions about that as written, in fact, in our report. The criteria for selecting particular cooperatives to assist are sufficiently broad so that we think there might be some administrative problem involved in it.

Senator TAFT. It runs up about fifteen million a year?

Mr. KINGSLEY. Ten million the first year and fifteen million thereafter.

Senator PEPPER. Senator, Senator Humphrey I think was very much interested in that phase of the matter, and has had a bit of contact with farm cooperatives and the like about its recommendations.

Senator TAFT. Title V, Grants to States for State and Local Health Work. That is the local public-health units section; is it?

Mr. KINGSLEY. Yes, and I think that is identical with the bill that is before——

Senator TAFT. We are now considering it in a separate bill.

Mr. KINGSLEY. Yes, sir.

Senator MURRAY. That is before the Hill committee.

Mr. KINGSLEY. The Hill subcommittee; yes, sir.

Senator MURRAY. And also title III.

Senator HILL. We have concluded hearings on that bill, too, Mr. Chairman, and hope to go into executive session on it this week.

Senator TAFT. Title VI, Research in Child Life and Grants for Maternal and Child Health and Crippled Children's Services. Part (b) grants to States, is just an extension of the existing rule on maternal and child-health program?

Mr. KINGSLEY. Yes, and the research title is substantially identical except for the amount involved, with a bill introduced by Senator Douglas which I think is before this committee.

Mr. KINGSLEY. His bill, as I recall, provides for $7,500,000 for research grants, and this particular title provides for $10,000,000.

Senator TAFT. Has it anything to do with health?

Mr. KINGSLEY. Well, the general approach here has something to do with health ultimately, but there would be no research projects specifically in, let us say, infantile paralysis or a particular disease.

Senator TAFT. It sounds more like psychology than health.

Mr. KINGSLEY. Well, it would provide for broad integrated programs, study in terms of the effect of environment upon the child, and so on, involving almost all the social sciences rather than exclusively the biological sciences.

Senator TAFT. It rather seems to me to be the subject of a separate bill. I did not study the exact provisions of it.

Title VII is the prepaid personal health and insurance benefits.

Mr. KINGSLEY. Yes, sir.

Senator TAFT. Was this prepared in contrast to some of the other parts of the bill, by the Federal Security Administration in cooperation with the sponsors?

Mr. KINGSLEY. Well, yes and no. It does not depart very far, with some modifications, but basically it resembles earlier bills which were prepared by, I believe, the counsel's office in the Federal Research Agency. In this particular instance, however, this is not specifically a bill which was prepared by us.

In a few instances it perhaps departs in some small detail from what we would have suggested. It was prepared by the sponsors. We provided some assistance in drafting. We loaned one of our lawyers——

Senator TAFT. Well, do you approve of all of it? You say there are some things you might question? In what respect does it differ from the ideas of the Federal Security Administration?

Mr. KINGSLEY. Well, there are some things that need to be, in our judgment, spelled out in more detail. There is a problem as to what is a specialist, for example, under section 711. By and large, subject to some small details which again we have spelled out in our report on the bill, it does correspond with our views.

Senator TAFT. This insurance is paid——

Mr. KINGSLEY. One other point, if I might interrupt, Senator Taft. A major point seems to us to be that the methods of allocating funds under this title as written to the States, the methods of allocating funds are a little unprecise. Now whether they can be made more precise, I do not know.

We would prefer, if a formula could be devised, an objective formula, to have such a formula. Some of our people have been working on that, but as it is written now it would be the guide to the Administrator or to the National Health Insurance Board in allocating funds as to just what basis you ought to move under, and the more precise you can make it, the less trouble you can get into.

Senator TAFT. How can you vary between the States? You have to provide the money that is called for by the operations system. There is no dividing of any money between the States, is there?

Mr. KINGSLEY. Yes. Under this you would——

Senator TAFT. You insure people and give them a certain health service. Then you have got to give them that service no matter what State they are in.

Mr. KINGSLEY. Well, as this bill is written the maximum amounts which could be provided under the specific language of this bill would be a 3-percent pay-roll tax provided by workers and employers, half by each, plus the equivalent of 1 percent of pay roll provided out of general revenue, or a total of 4 percent which, on the basis of the present tax base would be a total of about $5,600,000,000, or something of that kind, and that would have to be divided up in some way.

Senator TAFT. That is not in this bill, is it?

Mr. KINGSLEY. Yes, sir; I believe it is. I will have to look in the index. It is fiscal provisions, page 147. Now under (b) it reads:

> There shall be appropriated to the account for the fiscal year ending June 30, 1952, and for each fiscal year thereafter—
>
> (1) Sums equal to 3 percent of all wages estimated to be received during such fiscal year;
>
> (2) Sums equal to the estimated cost of furnishing dental services and home-nursing services as personal health-service benefits during such fiscal year;
>
> (3) Any further sums required to meet expenditures to carry out this title.

I take (d) to be a general limitation upon those provisions.

Senator TAFT. You cannot find any place where there is any tax levied.

Mr. KINGSLEY. No.

Senator TAFT. Is that what is contemplated, do you know, a 3-percent pay-roll tax?

Mr. KINGSLEY. Yes, sir.

Senator TAFT. There is nothing in here about dividing it between the employer and employee.

Mr. KINGSLEY. No, I think that is correct.

Senator TAFT. That was left out so the bill would not go to the Finance Committee, was it not?

Mr. KINGSLEY. That may have had something to do with it.

Senator TAFT. But to get this picture complete, there should be added to this bill, or the bill will be followed by a tax bill which levies 1½ percent on the worker and 1½ percent on each employer. Is that correct?

Mr. KINGSLEY. Yes, sir.

Senator TAFT. What about the self-employed?

Mr. KINGSLEY. Self-employed would pay 2¼ percent.

Senator TAFT. Why do they pay 2¼ percent against 3?

Mr. KINGSLEY. Well, it is an arbitrary decision. It is their full part plus half of the employer's, or the full part of the employer plus half of the worker's part.

Senator TAFT. Is it 2¼ percent of their income up to $4,800?

Mr. KINGSLEY. Of income up to $4,800; yes, sir.

Senator TAFT. Income derived from business?

Mr. KINGSLEY. That is right, of net income up to $4,800.

Senator TAFT. Now what is this 1 percent on page 148?

Mr. KINGSLEY. One percent is a limitation upon the contributions from general revenue. It provides that the maximum contribution, as I would read it, from general revenue in the years '52 to '54—fiscal years '52 to '54—shall be equal to one-half of 1 percent of aggregate pay roll, and thereafter equal to 1 percent of aggregate pay roll.

Senator TAFT. Where is that?

Mr. KINGSLEY. That is in subsection (d) of section 771.

Senator TAFT. Well, that is the 3 percent starting at a half percent and it then goes on up to 1. That does not cover (c). What is that 1 percent in (c)? Is that just a 1-year reserve?

Mr. KINGSLEY. In (c) the first appropriation is the first year reserve, and thereafter whether this language says it or not, I believe the intent of that would be that there shall be an over-all limitation in terms of the contribution out of general revenue.

Senator TAFT. So you figure 3 percent will come out of pay-roll tax and 1 percent out of general revenue?

Mr. KINGLEY. Or a total of 4 percent.

Senator TAFT. And 4 percent you figure on $140,000,000,000——

Mr. KINGSLEY. About $140,000,000,000; yes, sir.

Senator TAFT. $140,000,000,000 of pay roll. Just going back to those self-employed, if this thing costs 3 percent plus 1 percent, who pays the rest of the self-employeds' money? They only pay 2¼. Do the general taxpayers pay it?

Mr. KINGSLEY. I would think that comes out of general revenue.

Senator TAFT. I do not quite see the basis for the distinction.

Senator PEPPER. Mr. Kingsley, you said not to exceed 1 percent, did you not?

Mr. KINGSLEY. Yes, sir.

Senator PEPPER. Not to exceed 1 percent out of the Government Treasury.

Mr. KINGSLEY. Now, of course, as far as the self-employed are concerned, well, for that matter, as far as any of this is concerned, as Senator Taft points out, it would take another bill in terms of providing the money. These are our recommendations. I would certainly admit on the self-employed it is a purely arbitrary type of thing.

Senator TAFT. I notice, by the way, in the division of national income in these economic indicators published by the Joint Committee on Economic Report, the compensation of employees is $142,000,000 and that is just employees without counting the self-employed.

Mr. KINGSLEY. Yes, sir.

Senator TAFT. That is the first quarter of 1949, so that your total figure might have to be figured on a larger basis than $140,000,000,000, I take it.

Mr. KINGSLEY. Well, of course, there is no $4,800 limitation there.

Senator TAFT. Yes; that is correct. That reduces the total.

Mr. KINGSLEY. And I believe—at least our people tell me that on the basis of the $4,800 limitation it is approximately $140,000,000,000—maybe $141,000,000,000.

Senator TAFT. About $5,600,000,000. Do you know what the British cost is today?

Mr. KINGSLEY. Well, I think it is about $600,000,000, if I recall, but I would not want to be hung on that.

Senator TAFT. The appropriation proposed for national health services in Great Britain for fiscal 1949 budget is £263,000,000, which, multiplied by 4. is $1,053,000,000, and there are three times as many people, approximately, in the United States, so that would be $3,160,000,000. My estimate is that the type of services and cost of living, so to speak, the payments for doctors and all, would be nearly double here what it is in England.

Mr. KINGSLEY. It would be substantially higher, in any event; yes.

Senator TAFT. So that would more or less accord with your general estimate of $5,600,000,000, would it not?

Mr. KINGSLEY. Yes.

Senator TAFT. Now, that money is levied and collected by the Internal Revenue Bureau to be paid into the Treasury.

Mr. KINGSLEY. Yes, sir; in a separate account.

Senator TAFT. Under this provision, Congress is authorized and more or less required, I would assume, to appropriate that sum into a special fund known as the personal health service account.

Mr. KINGSLEY. Yes, sir.

Senator TAFT. Then what happens to that?

Mr. KINGSLEY. The personal health services account is then, aside from the provisions for a reserve—there are some provisions here for a reserve at the beginning of 10 percent—aside from those provisions, and later 5 percent—that fund is allocated to the several States by the National Health Insurance Board who are undertaking to provide this program.

Now, as I would read the bill, I think that the States—well, the State does have to file a State plan and to have approval to participate in the program. Once that has been done, then this fund would be allocated to them, and that is in section 772. It begins on page 149.

In section 772 (a) it lists the bases upon which the allocation is to be made. Now as I have already indicated, these are very broad, and if we could get more specific ones, we would prefer it from an administrative standpoint.

Senator TAFT. Now, as a matter of fact, does not the Federal Government keep a complete record of millions of people who pay these funds? Is that not all kept here in Washington?

Mr. KINGSLEY. Yes, sir; that is one of the advantages of this, that so far as the same people are covered both under OSI and under this, and our recommendation for expenses of coverage under OSI would make them identical for the coverage provided under S. 1679, so far as the coverage is identical, the same records can be used precisely, and there would be a considerable saving in administrative costs as a result of that.

You will note on page 152 that administrative costs cannot in any fiscal year exceed 5 percent of the aggregate. Well, that is allotments to the States, but it would be even less than that insofar as the Federal Government is concerned.

Senator TAFT. Going back for a moment, before I get to the point I want to bring out, the costs of indigent care of which we spoke would be in addition to this $5,600,000,000, would it not?

Mr. KINGSLEY. Yes, sir.

Senator TAFT. Whether it is handled under this bill, the provision to which we referred, or whether it is handled under the other bill.

Mr. KINGSLEY. Yes, sir; that is correct.

Senator TAFT. It would be in addition to this figure?

Mr. KINGSLEY. We have estimated that our recommended amendments to the Social Security Act which the Ways and Means Committee has considered, might cost as much as $200,000,000.

Senator PEPPER. That is for indigents?

Mr. KINGSLEY. For indigents.

Senator PEPPER. For people not fully employed?

Mr. KINGSLEY. It is for people actually on relief, so in effect they are being taken care of now by one means or another.

Senator TAFT. That is a very small proportion, is it not? That is only one twenty-eighth, or around 3 percent of the total falling in that class. Is that not a very small proportion to calculate for the indigents?

Mr. KINGSLEY. Of course, it is on a matching proposition as far as these particular amendments are concerned, so that that would be, well, the States would expend at least that much.

Senator TAFT. Now this subject of the States, this business of the money going to the States and State plans is entirely new, is it not, in this type of bill?

Mr. KINGSLEY. I believe that it is a departure from the earlier bills, at least from the first bill.

Senator TAFT. Is it not a fact that the States have no discretion in what they pay out, the amount they pay out or the classes they take care of? Are not the States under this bill purely agents of the Federal Government?

Mr. KINGSLEY. In effect; yes, sir.

Senator TAFT. And they are guided by regulations made by the Surgeon General and the National Health Insurance Board.

Mr. KINGSLEY. And an advisory board.

Senator TAFT. Who pays the salaries and wages of the State personnel who handle it?

Mr. KINGSLEY. They are paid by the State, but the administrative costs are included in the Federal money.

Senator TAFT. Is this not a Federal program, and is not the introduction of the States in here merely an effort to make it a decentralization of administration?

Mr. KINGSLEY. I would describe it as a Federal program with highly decentralized administration.

Senator TAFT. Yet, in effect, the States must take orders from the Federal bureau; must they not? Take, for example, regulations; say, regulations setting up under what conditions a man should have the right to have the State pay for the expense of an X-ray. That would be governed the same in every State by regulations issued by the Federal bureau; would it not?

Mr. KINGSLEY. Well, on that particular illustration, Senator, I would not be certain. In general, the types of regulations which can be issued—I am looking for the section now—by the National Board are rather limited and broad, and there is a good deal of authority in terms of what the State can do, and even more in terms of what the localities can do under this.

Senator TAFT. I read to you from pages 106 and 107, section 702, where it says:

> Medical services, hospital services, and, except as otherwise provided in subsection (p) of this section, all other personal health services specified in section 701 shall be made available as benefits to eligible individuals in all health-service areas within the United States.

That is a compulsory requirement that the State do it, and then in (b):

> If the Board, after consultation with the advisory council, finds that the personnel or facilities or funds that are or can be made available are inadequate to insure the provision of all services included as dental, home nursing, or auxiliary services under section 701 of this title, it may by regulation limit for a specified period the services which may be provided as benefits, or modify the extent to which, or the circumstances under which, they will be provided to eligible individuals.

Mr. KINGSLEY. Of course that is very specific in terms of these particular things; the dental and home nursing are auxiliary services.

Senator PEPPER. But, Senator, you did not read line 13. You left the impression by what you read that there was a mandatory requirement to give all these services to every covered person, but in line 13 it says:

> as rapidly and as completely as possible having regard for the availability of the professional and technical personnel and the hospital and other facilities.

Senator TAFT. I was only trying to find out whether there was any discretion left to the States at all, or whether this power of the Board to make regulations and withhold or modify services, those must be uniform throughout the United States, I suppose, those regulations.

Senator PEPPER. Mr. Kingsley, there is a State agency and a local authority. As a matter of fact, it is the physician, the general physician who determines whether you get a specialist or not, for example, is it not?

Mr. KINGSLEY. Yes; services of a specialist are available on referral of the general practitioner.

Senator PEPPER. That is on the order of a general practitioner?

Mr. KINGSLEY. Yes, sir.

Senator PEPPER. Do not these local boards and State agencies have authority for the general administration of the program?

Mr. KINGSLEY. They do, as I would read it; yes.

Senator TAFT. Except that the Board may change the regulations under which they operate every day, may they not, and that applies to all 48 States just as if they were branches of a Federal department. Am I correct there ?

Mr. KINGSLEY. Well, I think that is not true because of the rather specific provisions in respect to the State plans. What shall be in State plans is outlined in some detail, and I would take it that no national organization, no national administrator could refuse to approve a State plan which met those broad specifications on the basis of any regulations it would draw up itself.

Section 712, on page 113, really outlines what a State plan has to contain. It has to designate a single agency for its State administration, has to provide for the designation of a State advisory committee including both professional and lay people, provide for decentralizing administration for the localities, it has to provide for a merit system for making surveys of the resources and needs of the States, for such reports as the Board may require; it has to provide for safeguarding Federal funds, provide for cooperation with other public agencies of the States or its public political subdivisions which are concerned with related programs. Then it says:

> The Board shall approve any State plan which complies with these provisions.

Senator TAFT. In other words, the States have no right to say whom they will serve and whom they will not serve. All of these provisions of the State plan seem to me to be merely administrative. It does not even suggest that a State could say, "We are not going to do this or that," or say that they will not comply with the regulation made by the Federal Government as to the dispensation.

Mr. KINGSLEY. That is correct. Anybody who is covered by this bill would have to be provided with services under a State plan. This is a national determination of coverage.

Senator PEPPER. Mr. Kingsley, if the Senator will allow me to interrupt, on page 130 there is a declaration of policies, is there not, which reads as follows:

It is the intent of Congress that the benefits provided—

this is section 741—

under this title be administered wherever possible by the several States, in accordance with plans of operations submitted and approved as provided in this part, and in each State insofar as feasible by the same State agency which administers or supervises the administration of the State's general public health and maternal and child health programs.

I mean it is obviously the intention of the act as much as possible to put the finality of decision at the local level in the hands of the States.

Mr. KINGSLEY. Yes, I would think, Senator Pepper, that that is quite clear in terms of the way in which this whole administration section is developed.

Senator TAFT. And then on page 134, if the States does not submit a plan, then the Federal Government steps right in and does it anyway itself, is that not correct?

Mr. KINGSLEY. Yes, sir, that is correct. We start out with a complete national coverage. We then contract out of it, in effect, if the State wishes to carry out the program.

Senator TAFT. Well, in effect it is an attempt to say that instead of having local administrative offices under the name of the Federal Government, the administration is by State officers but the State officers are subject to the direction, regulations as far as I can see, in every respect of the Federal bureau which bosses the job.

Mr. KINGSLEY. Well, of course I would not agree in every respect.

Senator PEPPER. May I interrupt again? There are two points. In the first place, may I call your attention to page 134, where, after the provisions of the State plan which you referred to a moment ago, the following appears:

No change in a State plan shall be required within 1 year after initial approval thereof, or within 1 year after any change thereafter required therein, by reason of any change in the regulations or standards prescribed pursuant to this title.

Senator TAFT. Which page is that, Senator Pepper?

Senator PEPPER. Page 134, the top of the page right after the content of these State plans, there appears to be a prohibition against the Federal Government within a period of a year requiring any alteration in these plans. It says:

No change in a State plan shall be required within 1 year after initial approval thereof, or within 1 year after any change thereafter required therein, by reason of any change in the regulations or standards prescribed pursuant to this title, except with the consent of the State or in accordance with further action by Congress.

So that once a State submits a plan and it is approved, the Federal Government cannot require it to be changed within a year after it is initially submitted. It cannot require any change in a plan once approved for a period of a year thereafter. That is correct, is it not, the language I read?

Mr. KINGSLEY. Yes.

Senator TAFT. My suggestion was that there was not anything in the plan that anybody would care much about changing. It does not have anything to do with the actual rules by which medicine is dispensed.

Senator PEPPER. Now one other thing, Mr. Kingsley. Is it not the State which employs the personnel which administers the program?

Mr. KINGSLEY. Yes, sir.

Senator PEPPER. And I believe the State prescribes the compensation, does it not, that they receive?

Mr. KINGSLEY. Yes, sir, the only provision restricting personnel so far as the State is concerned is that they shall be applied under a merit system. I would like to say in respect to Senator Taft's last comment that the Federal Government would regulate everything having to do with medicine.

It seems to me that quite the contrary is true, that the basic things having to do with the provision of the medical services are regulated by the local community and by either the local administrative officer or the local administrative board, whichever a State plan provides for.

It is at that point where determinations are made as to the local supply of services and as to the methods by which physicians are going to be paid, and where local complaints are heard and so on, that the real administration occurs so far as the provision of medical services is concerned.

Senator PEPPER. Well, now just to emphasize that point, to let it come from you, there is no authority in the Federal Government that has anything to do with the application of professional treatment?

Mr. KINGSLEY. None whatever.

Senator PEPPER. The Government of the United States has nothing to do with the kind of treatment or the lack of treatment that a qualified physician or technician prescribes?

Mr. KINGSLEY. Absolutely not.

Senator PEPPER. The other thing is, it is very clear in the intention of this act, is it not, that there is no intention on the part of Congress or desire to grant the authority to interfere with the free choice of doctor or other technician that the patient may make?

Mr. KINGSLEY. No, sir; it is quite specifically provided that there shall be no such interference.

Senator PEPPER. And the doctor also or the technician is also allowed a free choice with respect to the patient he serves?

Mr. KINGSLEY. That is correct.

Senator PEPPER. And doctors and other technicians determine voluntarily whether they will come into the plan or not, do they not?

They may come partially in or they may stay out altogether or they may agree to accept the fees, the standard and scale of fees that the agency pays?

Mr. KINGSLEY. That is correct.

Senator TAFT. But as to the provision in section 717, I notice it says that each agreement that is made with doctors or hospitals or anybody else—

> made under this part shall specify the class or classes of services to be furnished or provided pursuant to its terms, shall contain an undertaking to comply with this title and with regulations prescribed thereunder—

that is by the Federal Government—

> shall be made upon terms and conditions consistent with the efficient and economic administration of this title, and shall continue in force for such period and be terminable upon such notice as may be agreed upon.

Every agreement made is subject to the regulations issued by the Surgeon General.

Mr. KINGSLEY. That is every agreement made under section 716, agreements with voluntary health insurance and other organizations.

Senator TAFT. Also 715, agreements with individual practitioners, hospitals and others. 717 applies to both, also 714, auxiliary services.

Senator PEPPER. Mr. Kingsley, if there should be any doubt, if there should be any reason at all for anyone to believe or fear that this power to make regulations interfered with these freedoms that we just discussed a moment ago, why you would have no objection to it being written into the law in clear terms that those freedoms cannot be interfered by regulations or any other way?

Mr. KINGSLEY. None whatever. In fact, more specifically the rulemaking authority of the national board is spelled out, the better it is administratively.

Senator TAFT. And does the act require the payment of this money per service, not per capita, not on a salary basis?

Mr. KINGSLEY. No, sir. It provides three alternative methods on page 117 of section 718. The local community can decide, the doctors and the patients.

Senator TAFT. Having once started a per capita system, does not this business of your selecting your doctor and having the doctor select you go out the window the moment you have a per capita pay system?

Mr. KINGSLEY. No: because you can change it at any time. Now it is limited in this sense.

Senator TAFT. As a practical matter has not the experience been in England that where you have a panel of that sort, that right practically disappears? You get away from the payment per service basis.

Mr. KINGSLEY. I do not think so, Senator. Now it is limited in this sense. You have a very popular doctor in an area, obviously he is going to have to limit the number of people he can take, but he does it already. He does it under the present system. He refused patients, and to that extent I cannot go to him if he is all filled up. The same thing would be true under this.

Senator TAFT. You never have gone to him. The claim is if you have a doctor, you can keep him. You have never been to that doctor under the present system. If he has had you as a patient, he will always take you back, but under the panel system, he cannot.

Mr. KINGSLEY. You can always keep the same doctor under these provisions if, (a) you wanted to, (b) he was in the system, and (c) he wanted you. If those three conditions were met, you could keep the same doctor.

Senator PEPPER. But if he wants to get you off of his panel as soon as you can get on some other panel, he can get you off of his panel?

Mr. KINGSLEY. Oh, yes; just as now he can say, "I do not want to treat you any more."

Senator PEPPER. And if you do not like him and want to get off of his panel, you can transfer to another?

Mr. KINGSLEY. Yes, sir.

Senator MURRAY. We will have no hearing this afternoon. This will go over until tomorrow morning at 10 o'clock.

Senator TAFT. I assume that the Federal Security Administration will be back later on the details of the bill?

Mr. KINGSLEY. I expect so; yes, Senator.

(Whereupon, at 12:05 p. m., the hearing was adjourned to reconvene on Tuesday, May 24, 1949, at 10 a. m.)

NATIONAL HEALTH PROGRAM OF 1949

TUESDAY, MAY 24, 1949

United States Senate,
Subcommittee on Health of the
Committee on Labor and Public Welfare,
Washington, D. C.

The subcommittee met, pursuant to adjournment, at 10:00 a. m., in the committee hearing room, Senator James E. Murray (chairman), presiding.

Present: Senators Murray, Pepper, Humphrey, Taft, and Donnell.

Senator Murray. The hearing will come to order.

Yesterday S. 1679 was explained and discussed briefly. Today we expect to receive explanations of S. 1581, S. 1456, and S. 1106. We will hear testimony on S. 1581, from Senator Taft and Senator Donnell, on S. 1456 from Senator Hill and Mr. Bugbee, the director of the American Hospital Association, and on S. 1106 from Senator Lodge.

Our first witness this morning will be the distinguished Senator from Ohio, a member of this committee, and Senator Donnell, who has been very active and cooperative with me for several years.

We are very glad to have you both here this morning.

STATEMENT OF HON. ROBERT A. TAFT, A UNITED STATES SENATOR FROM THE STATE OF OHIO

Senator Taft. Mr. Chairman and members of the committee, Senator Donnell and I appear here today to present to the committee and explain Senate bill 1581, which we introduced in common with Senator Smith of New Jersey. Senator Smith is, unfortunately, ill at home and is unable to appear with us at this time.

Mr. Chairman, I think we all realize the general situation and the problems which this committee has been trying to meet in a number of different ways. We have today a very extensive medical system in the United States. We feel that it is a good system and that the problems which arise out of it are problems which would arise under any circumstances and which should be met by constructive study and by the adoption of measures which may effect a steady improvement in that system, not by throwing away the system and beginning over again.

In the first place, of course, we have the problems of public health, research, and preventive medicine. That field has been and is today the field of Government primarily. There is, of course, some very important private research in that field, particularly in basic medical problems. There is a good deal of scattered work in the field of public health among private charitable institutions. But in general, of course, it cannot be done on a commercial basis at all and it is and should be the function of Government.

This function includes the diagnosis and inspection of the health of school children and other general measures directed to preventing the development of disease. The Government has a wide field in which those functions can be increased and improved. I think it is the first and primary function of Government to bring about that improvement.

The second feature of our general medical system is that of providing medical care. It has always been assumed in this country that those able to pay for medical care would buy their own medical service, just as under any system, except a socialistic system, they buy their own food, their own housing, their own clothing, and their own automobiles.

Obviously, many families have difficulty in providing food, housing, clothing, and automobiles, but no more difficulty, certainly, in providing medical care.

The general appeal in this country has always been for those who are unable to buy medical care, unable to pay for their own expenses in the medical field. We have brought about, in order to meet that situation, a great development of private charity throughout the United States. Those charities have then been supported by Community Chest organizations throughout the States, which lay a tremendous amount of their appeal to the people for funds on the necessity for providing adequate medical care for those who are unable to pay for it.

That work has been supplemented by the States and local communities through their general hospitals, free nursing and medical service in hospitals, services of preliminary and preventive nature through public health units, so that medical care has already been made available to a large proportion of those who are unable to pay for it in the United States.

Undoubtedly, in that system there are gaps, particularly in rural districts and poorer districts in the cities, and we have a very definite interest in trying to fill up those gaps.

There also developed the realization that illness may be concentrated; that illness in the case of families who can pay for medical care may be concentrated in a single year and, thus, assume the nature of a catastrophe.

This has ordinarily been met in the past by the furnishing of the same kind of free medical care as that furnished to those who could not pay for it at all. But it was conceived that that problem could be met by providing medical insurance that would take care of extreme cases of illness, just as fire insurance takes care of the destruction of a single building by fire and the tremendous loss, which may occur at one time but which through the insurance system can be spread over a great number of people and a great length of time. This insurance has been gradually developing on a private basis and a not-for-profit basis in the United States until it is fairly generally available to the people.

In general, we believe that the present system has done an excellent job. I disagree entirely with Mr. Kingsley's statement on page 7 of his report that:

> It appears to be agreed that our present system of payment for medical care is totally inadequate.

I do not think that is at all true, and I think we have in this system as good a system of medical care as they have in any country in the world, with the possible exception of one or two small countries where their health problems are much less complicated and much easier to deal with.

Last year, when our committee met here, that is the Subcommittee on Health, which had more or less these same measures before it, the Brookings Institution was requested to make a study, at the request of Senator Smith, who was then chairman of the Subcommittee on Health of this committee. That study was made by George W. Bachman and Lewis Meriam, with the support of the Brookings Institution, and I assume this report, entitled "The Issue of Compulsory Health Insurance," will be furnished to every member of the committee, and I hope every member of the committee will read it, if they have not already done so.

The conclusions of that report are stated on page 67, and I quote:

> The conclusions based on this foundation—

the foundation of the evidence which had been reviewed—

are:

> 1. Probably no great nation in the world has among its white population better health than prevails in the United States. A few small homogeneous countries, such as New Zealand with respect to its white population, are slightly ahead of the United States as a whole, but certain States of the United States with larger populations equal them.
>
> 2. It is apparent that the United States under its voluntary system of medical care has made greater progress in the application of medical and sanitary science than any other country. This progress is now reflected in low mortality and morbidity rates of infectious diseases and in increased life expectancy. There is every reason to believe that these trends will continue unabated under our present system of medical care.
>
> 3. The nonwhites in the United States have materially poorer health than the whites, but the evidence does not indicate that this condition is primarily or even mainly due to inadequacy of medical care.
>
> 4. The advances in health among both the whites and the nonwhites that have been made in the United States in the past four decades do not suggest basic defects in the American system.

There are various criticisms of the system in the other recommendations, although I will not read the entire recommendations, because it is available in its entirety to the committee, and there are, of course, many defects in the system, but I only want to question the basis on which we are asked to throw away the present system in the claim made that the present system is totally inadequate.

There is one other set of figures in this report which I would like to refer to on page 84 regarding infant mortality rates for selected countries.

It is interesting that that infant mortality rate in the United States and in all countries has steadily decreased during the years from 1921 to 1943. In the United States it has decreased from 74 to 40. In Canada it was 98 in 1921, a good deal higher than here, and has decreased now to 54, still a bit higher than the United States, which is 40.

In the United Kingdom the infant mortality rate in 1921 was 78, as compared to 74 in the United States; it is now 52, as compared to 40, so that our improvement has been substantially greater in those years than the improvement in the United Kingdom.

Senator PEPPER. Do you want to be interrupted now, or do you want to finish?

Senator TAFT. I would like to finish the table first, if you don't mind.

The Netherlands in 1921 was 64 as compared to 74 in the United States, reduced to 40 in 1943 as compared to 40 in the United States, the same.

In Sweden, which is probably the best of the European countries, it was 60 in 1921 as against 74 in the United States, reduced to 29 in 1943, which is the lowest of any country. Sweden is a small, healthy country with a very single and healthy white race.

I only cite that to show that under this system of medical care, which has been attacked, infant mortality rates in the United States have been reduced by nearly 50 percent from 1921 to 1943, or in 22 years.

Go ahead, Senator.

Senator Pepper. I was just going to ask you if you did not think that the diet and the nutritional opportunities that probably the people of this country had made a favorable comparison between us and some other countries which do not have such high nutritional opportunities for their children.

Senator Taft. I would assume so, although this is all practically prewar, these statistics; I think there are various reasons for this. I only suggest that, after all, the medical care system and the prescription of diet and finding out what you should give must be one of the important factors, but it is hardly conceivable to me that you could make such a tremendous improvement under a system of medical care which is, quoting from Mr. Kingsley, "totally inadequate."

Senator Pepper. Is it your impression that we did a good bit to save the lives of children and mothers with the service program that we had in effect during the war where mothers were assured better medical care and attention than they had previously had an opportunity to enjoy?

Senator Taft. I think so; yes, that probably helped some, although there was a steady decrease every year all the way from 1921 to 1943; it was a constant improvement in infant mortality rates, due, of course, to public-health measures, medical care, and, as you say, the diet. I think most of the country had a fairly adequate diet if they knew what to do with it.

I think it is the application of diet and medical care and the knowledge developed which has probably effected this improvement all over the world—the knowledge of how children should be fed and what kind of diet they should pursue.

Our problem, therefore, as we looked at it, the authors of this bill, is, in the first place, to improve public-health measures. I say in that field I think the Government has a particular responsibility. Second, to improve and make systematic medical care available for all of those unable to pay, either because they are below a standard income or below an income which can afford to pay, or because their income at the moment is depleted by any particular cause or by any unusual illness.

The third is to see that insurance is available for those who desire it and who are able to pay for it.

Those, I think, are the main purposes of the bill which we have introduced.

Turning to S. 1581, title I establishes a National Health Agency. It attempts to combine in one division all of the health activities of the Federal Government, excepting the military and veterans' health. The authors of the bill feel the health is primarily a single problem;

that it is not a welfare problem primarily; that it is problem of providing medical care and health services of all kinds to reach all the people in the country; and that the fact that some are able to pay and others are not able to pay affords reason for classifying your assistance or the way in which you treat them, but that it does not justify the placing of all health activities under a Department of Welfare.

I may say that the report is more or less in accord with the Hoover Report on Medical Activities, made in March 1949, whose first recommendation is—

> To accomplish these purposes, the Commission recommends the establishment of a United Medical Administration into which would be consolidated most of the large-scale activities of the Federal Government in the fields of medical care, medical research, and public health (in which we include preventive medicine).

On that issue the Commission was somewhat divided. They voted 8 to 3 in favor of that particular recommendation regarding the establishment of a separate Bureau of Health.

Two other commissioners dissented from the placing of the military health operations within the Federal Department of Health. We did not do that. I think that is a question of reorganization more than it is of the general character of health activity.

In any event, in section 1 we follow the general rules of that Commission. I am glad to see that the Congress has followed that Commission in the reorganization of the State Department, it seems about to follow it in the reorganization of the military forces, and I hope very much they may see fit to follow it in the case of their recommendations regarding a separate health agency.

Senator PEPPER. Senator, what do you put under this agency which is not now under the jurisdiction of the Federal Security Administrator?

Senator TAFT. I think nothing. The Children's Bureau, I think, has been transferred already under the previous plan.

Senator PEPPER. I think so.

Senator TAFT. It was not when we first drew the bill, we transferred the Children's Bureau. We direct the Director of the Budget to make a study of the activities of the several departments and agencies of the Federal Government with a view to determining whether any activities of such departments and agencies relating to health, but not transferred to the agency by this title should, in the interest of economy and efficiency of administration, be transferred to the agency; and to complete such study and report the results thereof to the Congress on or before December 31, 1949.

The Veterans' Administration is the most important really overlapping activity.

Senator PEPPER. But your bill would make the health agency have cabinet status, would it?

Senator TAFT. No; it is an independent agency and I understand it is so under the Hoover Commission report. I personally have supported the idea of a Department of Health, Welfare, and Education, as you know, and I would not object to putting this health agency into such a department.

My only view is that if we did that, it should be a very distinct bureau of that agency and that the head of the health activity, the Health Bureau, should be responsible directly to the Secretary who sat in the Cabinet, that he should have direct access to that Secretary and not have some intermediate Under Secretary or others through whom he would have to go.

The bill I supported here last year had that provision, I think three Under Secretaries, one for Health, one for Education, and one for Welfare.

Various other parts of the bill cover this question of public health. Some of them are not before this committee, but we feel that the public health end of the bill and of the activities of this committee are just as important as the general problem of medical care. I think the authors of the bill have always favored the various bills for increased research in cancer, heart, psychiatry, dentistry; I cooperated with Senator Hill in rewriting the Hill-Burton bill after Senator Burton was appointed to the Court, and we have generally, all of us, favored the measures which gave Government aid in this general field of public health.

Senator HILL. The Senator is also one of the authors of that bill now.

Senator TAFT. I am coming to that. Title IV of this general bill, page 38, extends the hospital bill, gives more money for the general purposes of that bill, the Hill-Burton bill, and provides an easier matching process by which poorer States are more able to match than they are under the present bill.

I might say that I think Senator Hill and I had this in our original bill and the House took it out, so we are trying the House again to see if we cannot get a more liberal matching provision for the hospital bill.

Senator PEPPER. I hope, if I may say so, that the Senator from Ohio and the Senator from Alabama agree to the Holland-Pepper amendment to their amendment.

Senator TAFT. That is a special case.

Senator HILL. That is a question of retroactivity.

Senator PEPPER. Not ex post facto.

Senator HILL. Not at all.

Senator TAFT. As title IV intends to increase the facilities for health services, title VI on page 52 deals with the general question of medical education, which is coming before this committee by more direct testimony shortly.

Senator MURRAY. Right there, titles IV and V of your bill have been considered by Senator Hill's subcommittee.

Senator TAFT. That is correct.

Senator MURRAY. So that you do not intend to go into that in detail, do you?

Senator TAFT. That is correct, and I do not intend to go into the whole thing in tremendous detail. I merely want to present to the committee what is in the bill.

Title VI on page 52 deals with the problem of providing more personnel for health service, and it seems to be universally agreed that more personnel is necessary as health service is expanded by whatever means it may be expanded.

Senator PEPPER. What is your plan of aid?

Senator TAFT. I have talked to deans of medical schools, I have talked to the representatives of other schools, I am on the board of the Yale University myself, and one of our main headaches is the medical school, which draws tremendously on all the funds of the university.

I cannot find any general agreement as to just what ought to be done. Rather, I find different ideas everywhere.

We finally came to the conclusion that there ought to be a major study by a commission of distinguished men from all walks of life to try to work out the best possible system of giving Federal aid to medical education. The problem of Federal aid to higher education is a problem that has never been thoroughly studied or considered.

We set up here a commission of 16 commissioners, including the Surgeon General of the Public Health Service, the Commissioner of Education, the Chief Medical Director of the Department of Medicine and Surgery of the Veterans' Administration, and a representative of the Medical Services of the National Military Establishment—that makes four of them—and 12 commissioners to be appointed by the President, who shall be persons not otherwise in the employ of the Federal Government. Eight of those shall be persons outstanding in the field of medicine, dentistry, nursing, public health, or higher education who are familiar with the problems of manpower in the health professions. The other four may be any public citizens.

We feel that there should definitely be such a study on an extremely impartial basis. We are not satisfied with the studies made up to date by the Federal Security Administration. We think there should be such a commission.

In the meantime, because it was quite evident that the doctors, at least, were insufficient in number, we provided on page 56 a direct subsidy to all established medical schools of $500 for each student enrolled up to the average past enrollment of the school, and $750 for each student in excess of the average past enrollment, to give some encouragement to increase, but not the very wide difference proposed by the Federal Security Administration between three hundred and seventeen hundred.

Senator PEPPER. Do you allow any assistance for the enlargement of existing medical schools or construction of new ones?

Senator TAFT. No, we only did this temporarily because it takes so long to educate a doctor. We felt that the nurses could be left out, although we have no objection, on proper evidence of their great necessity, of inserting those other people. We left them out here because we did not have the evidence and because we felt that in most cases those people could be taken care of in a shorter time, but we felt that we had better get these doctors started as soon as we could.

Senator PEPPER. You do not make provision in your bill for scholarships for students?

Senator TAFT. No. Yesterday Mr. Kingsley testified there was no emergency about that. Whether you wanted it or not, there was no emergency. You have four or five times the number of applicants who are able to pay their way through. This commission would consider the question of scholarships, would consider the question of aid in the construction of medical schools and the equipping of medical schools. These are the three things covered by the other bill.

Our theory was we ought to have a study first in the nature of the kind of thing they do with a royal commission in England, to try to get some better crystallization of opinions as to what should be done than we have today among those who are familiar with the problems.

But, as I say, in the meantime to try to stimulate and help some schools which might go on the rocks completely, and to encourage them to keep up their enrollment and perhaps increase it somewhat, we have this additional money. Most of them take the position that they cannot increase their enrollment without having increased facilities and that the effort to give schools $1,700 for new students is an incentive to them to put on more than they could properly educate, and it is likely without increased equipment to result in a decrease in the quality of medical education.

Senator PEPPER. You mean to include then for future study, at least, provision of additional training facilities for dentists, technicians, nurses, et cetera?

Senator TAFT. Yes. I don't know whether it can be shown that there is an emergency. You see, this provides aid for 3 years while this study is being made. We hope it might be completed sooner than that, but it provides for 3 years.

We would not object, upon proper evidence, to including temporary aid for some of the other things such as, particularly, public health and, perhaps, graduate school students in medical schools.

I have been appealed to on the ground that we ought to do something for graduate study to provide teachers. They say, "We can get students, but we have no teachers to take care of them and this aid should be extended in particular to graduate students aiming at becoming teachers in medical schools."

You have to go back every time you do something, you have to go back and do something else to make the other step possible.

Senator PEPPER. In a lot of areas such as, for example, in my State, I am afraid it is going to be impossible to start a medical school, which we feel we should have, unless we can get some assistance in providing facilities, buildings, and equipment.

Senator TAFT. I think so, and this is my recollection, although I state it with some hesitation, that Dr. Parran had a plan for building up the number of medical students by increasing the schools, adding about 10 schools, I think. Certainly, this commission should consider such a provision. But, of course, if Florida wants a school, it is likely that every one of the other 30 States that do not have one would want one. We would probably have too many medical schools unless we developed them in a regional way, and there might not be a sufficient number of teachers to teach in them.

Title V of our bill, on page 42, is similar to the bill here which increased the Federal aid to States for local public-health units in order to spread local public-health units throughout all the counties in the United States. That is covered by Senator Hill's bill.

Title III was the provision of health service to the schools, the bill which has already been passed by the Senate.

I think, myself, if I had the complete say-so, that if this session of Congress could pass those four bills separately—the school health services, the local public health units, the hospital bill, and the medical education bill, either study or whatever may be done with it—that we would have accomplished a tremendous step forward in this whole field and in the field which I think does not produce any great controversies and will start us on the road toward better medical service, no matter what form ultimately the bill for medical care may take.

Senator PEPPER. That medical recruitment, could not we give some impetus to that?

Senator TAFT. I am not purporting to lay down a program. These four things are what we picked out as the most important.

In regard to the local public health units, you have the problem of personnel, whether if you expand those public health units, you will have enough personnel to man them.

Senator PEPPER. If we make our program really outstandingly creditable, if we could add a beginning on health insurance, it certainly would be a fine accomplishment, would it not?

Senator TAFT. I understood the chairman, apart from the merits of the plan which I will discuss briefly later, the chairman of this committee has stated he does not expect this session of Congress to deal with it; so I am only falling in with the line of the majority of the committee in suggesting a postponement of that particular matter.

Senator PEPPER. Let's do not take that as official, though.

Senator TAFT. Now, I come to the medical care plan, which is title II of the bill, beginning on page 11. The first part of this title is a provision for an appropriation of $5,000,000 for a survey to be made by the States on a matching basis on the providing of medical care in that State.

That is similar to the provision which we had in the hospital bill and which I think has been a most valuable provision, probably the most valuable provision of that bill, up to this time, certainly.

The difficulty with medical care and the whole medical situation in this country is it has been purely a casual growth, a hospital built here, some service started there, and the thing has not been ordinarily coordinated, even at the State level. There has been some improvement in that regard, but we have felt that is tremendously important that in each State they make a survey of the particular problems they have to deal with.

I do not think I can exaggerate the importance of that. One of the objections, I think, to throwing in a system of national health insurance and taking over the whole thing from a national standpoint is that we practically relieve the States of any further responsibility; and the scope of the national study, to my mind, will prevent its being as valuable as a survey made by each State of the particulal detailed provision of medical care in each section of that State. The problem of medical care is different in different localities and different States.

Different States have different kinds of people and different medical problems for different kinds of people. As a matter of fact, we have not gone so far in the general problem of medical care that we can say that any solution is the ultimate solution. There may be many different kinds of solutions, and one solution may be suitable for one State and another for another State. I do not think we need to go down the Socialist Party line on a national pattern to provide a system of medical care, and we should encourage the States to develop the particular system each State thinks is desirable.

Part B is the general provision providing for medical care. It follows the general plan of Federal aid to the States, leaving as much discretion to the States as possible and complete control of administration and complete control of the selection of the kind of plan they want to adopt within the general provisions contained in the standards, so to speak, prescribed by the Federal Government.

The essence of the State plan is set forth on page 16, paragraph 5, where it says that the plan must set forth, in order to get Federal aid, a State-wide program designed and calculated:

> (A) to provide, within 5 years, medical and hospital services without discrimination to all those families and individuals in the State unable to pay the whole cost thereof;
>
> (B) to provide dental services as far as practicable to such persons;
>
> (C) to encourage the development of voluntary medical, dental, and hospital insurance plans operated not for profit;
>
> (D) to provide for the establishment and staffing of general diagnostic facilities and the improvement of existing diagnostic facilities; and
>
> (E) to provide inducements to physicians and dentists to practice in areas which, without such inducements, would be unable to attract needed physicians or dentists.

In regard to (D), that is somewhat of an overlapping, and it may or may not be desirable to continue it in this bill. It covers the school health inspection, for instance, and health units, and various other provisions, and the hospital bill itself also, which permits the setting up of clinics.

In regard to (E), that is instead of providing the system of direct national subsidy to physicians in low-income areas which is set up in S. 1679.

I continue to quote from the bill:

> The services provided for under paragraphs (A) and (B) may, at the option of the State, be furnished in one or more of the following ways: In institutions, in the home, or in physicians' or dentists' offices. Such program may also provide for the furnishing of such services by means of payments (in the nature of premiums or partial premiums or the reimbursement of expenses or otherwise) by the State to any voluntary medical, dental, or hospital insurance plan or other plan operated not for profit. Such program may include and take account of services rendered or to be rendered by governmental subdivisions of the State, and by private nonprofit organizations, and may provide for payments to such subdivisions or organizations for services furnished to families or individuals. Such program may provide for the collection of proper charges of less than the total cost of such services (whether provided by the State, governmental subdivision, private organization or nonprofit fund) from persons unable to pay in whole but able to pay part therefor.

The essence of the plan is to see that every State provides free medical service for all those people in the State who are unable to pay the cost thereof.

Senator PEPPER. Do you mean as well as all those who are unable to pay the whole cost thereof?

Senator TAFT. Yes, to pay the whole cost thereof, and then they may provide for collecting part of that cost back.

The dental services are not made compulsory. That is, there is no provision that they have to extend dental services to everybody. The problem of dental service is a very expensive one and it is a question how far we should go in it. It is still somewhat experimental. Those most interested in dental services do not seem to think we should provide a universal requirement of dental service at the present time.

In general, the plan, as you see, is intended to provide for those who are unable to pay, leaving those who are able to pay for their medical service the job of paying for that medical service.

Senator PEPPER. Do you prescribe any standards of ability to pay?

Senator TAFT. No.

Senator PEPPER. Is not that the difficulty you encounter?

Senator TAFT. It seems to me that is something that can be determined and will be determined in cooperation between the States and the Federal department. What can a man pay? I do not know. The general theory is that medical care—I do not know whether it is the general theory, but take the cost of the proposed S. 1679, suggesting 4 percent of the pay roll. That would suggest that a man can afford to pay 4 percent of his income for medical care.

Senator PEPPER. Senator, you mean our bill?

Senator TAFT. Yes.

Senator PEPPER. It is 3 percent and then 1 percent, not to exceed 1 percent, out of general taxation.

Senator TAFT. General taxation. He will pay that 1 percent some other way but, in general, 4 percent. I see no reason why a family should not pay 4 percent for medical care.

That means a $2,500 family would pay $100, for which they could buy general medical and hospital insurance at the present time for the family. That suggests a standard.

I would not want to write such a standard into the bill. It seems to me that has to be worked out as you go on and will, of course, vary.

In housing, the general provision is that a man can afford to pay 20 percent for housing. That is a kind of a rule of thumb adopted in the housing bill. If he cannot get decent housing for 20 percent, then he is eligible for public housing. I see no reason why you should not have some such standard developed gradually in medical care, but I would prefer not to put it in the bill itself.

Now, in general, what we are trying to do is, one, to improve the providing of medical care to the poor, so to speak, which has always been a function of government, recognized from the beginning, recognized in England, recognized in this country, but not done as well as it could and should be done, I think largely because of the inability of States and localities through their limited tax powers and the fact that health is rather a fifth wheel in most local government activities.

So we give them Federal aid to enable them to do that job and we encourage the making of a survey so they can determine exactly what the job shall be. The purpose in general is to extend and improve the present medical system for such people and to make available to others some kind of voluntary insurance, if they wish to take that insurance.

I do not agree at all that insurance should be forced upon them if they do not want to take it any more than insurance for fire or insurance for any other activity in life is forced upon those who may or may not want that service.

I come from a family, some members of which never go to a doctor, cannot be induced to go into a doctor's office even when they ought to, and others that go to a doctor on the slightest excuse, without any real justification. I see no particular reason why we should be concerned by minor illnesses.

I believe that if a man wants to insure himself against illness, he should have that available. If he does not want to do it, I do not see why we should force it upon him.

Senator HUMPHREY. Have we not forced upon people insurance against automobile accidents in many States?

Senator TAFT. That is more for the people to whom they may do a direct injury. It is to protect the person they run into. That is a very different matter, I think.

Senator HUMPHREY. Is it not a bit of an analogy? Illness is not just a matter of the individual. It is also a community problem of some kind.

Senator TAFT. I do not see the parallel, and very few States require that automobile insurance, I may say. I think it is a good thing, and I would be for it.

Senator HUMPHREY. I was referring to the principle of compulsory insurance.

Senator TAFT. I think we should retain the freedom of, we will say, 75 percent of the citizens to choose their own kind of medical care, decide whether they want medical care or not, determine how they will get it, and the person from whom they are going to get it. I think we ought to preserve the rights of States and local communities to decide, free from Federal domination, the kind of medical system they want and the extent of the activity in which they are going to be engaged.

I think we ought to preserve the freedom of the medical profession to work out its own solutions, because I think in the long run it is much more likely to develop good medical service than a system administered under the direction of the State.

This plan is designed for that purpose.

Senator PEPPER. Senator, may I just ask you a few questions about this to illustrate how your plan——

Senator TAFT. Do you mind if I continue? I am going to contrast it to S. 1679 and then I will be glad to answer any questions.

Completing my discussion of our bill, the distinction between this plan and the administration plan is shown somewhat by the character of the regulations on page 24:

> The Director is authorized to make such administrative regulations as he finds necessary to carry out the provisions of this title.

We set up a National Medical and Dental Care Council of 12 members. If a State plan does not meet the approval of the Director, the State is not left solely subject to his arbitrary judgment, but they may appeal to the National Medical and Dental Care Council, which Council has the right to approve the plan in spite of the Director if they decide that it complies with the general provisions which I have read relating to the nature of the plan.

In contrast to S. 1679, the first tremendous contrast is the contrast between State control and National control. Under S. 1679 there is a State plan. There did not used to be. There did not used to be any pretense of a State plan in the earlier drafts of the bill we have had in past years, but this present State plan relates only to personnel and administration.

The State is subject and its officers are subject in every respect to the regulations made by the national bureau, made by the Surgeon General, and the National Council, whatever the body is that makes the regulations. The State is in effect only an agent to carry out the national plan.

It is an attempt to decentralize the administration. I would say that is certainly an improvement over attempting to have a completely

Federal bureau, although it has this disadvantage: That it does split up the responsibility.

Under our theory if the State does not do the job, the State is responsible, the Governor is responsible, the legislature is responsible. Under this if it is not done, the State officers and they are half blamed and the National Government is blamed the rest of the way, it may be due to regulations or it may be due to administration, and there is no concentration of responsibility, as I see it, under that particular system.

In this general field, this question of whether we do this through the States, let the States run the show, or whether we have the National Government do it, I want to call attention to this fact: That I do not think there has ever been a successful national administration of a regulatory operation extending down to every family and every farm and every person in the United States. I do not believe we have ever made a success of it. I think the country is too big to make a success of it.

We had the WPA, and it went out in a blaze of condemnation and disapproval. We chose to do it on a national basis. It went out. We had the OPA and that went out in a general national disapproval because the attempt to make regulations in Washington to cover the entire United States is a job that I do not think any government can successfully do, and, certainly, it cannot do it and preserve any kind of responsibility to the people. The national bureau is too far away.

I think we are bound to get rid of rent control very shortly for very largely the same reason, and that is not nearly as extensive as it is contemplated that this shall be.

The reason I got elected in 1938 was largely that the farmers deeply resented the extreme of Federal regulation on what they could raise and what they could not raise, which reached its height in 1937 and then steadily decreased after that and disappeared entirely during the war. I just do not believe that the National Government can do a good job in the field of detailed regulation, and I do not think the people will stand for it for any very considerable length of time.

So that the first contrast between the two measures deals with the question that we propose a State control, just as largely as is possible, consistent with the general purpose we are trying to accomplish, as contrasted to what I believe to be a complete national control in spite of the rather elaborate provisions for States taking over the administration, if they wish to do so.

In the second place, it is suggested that S. 1679 is insurance. We are not setting up insurance. I suggest to you that S. 1679 is not insurance at all, but it is taxation. It levies a pay-roll tax, 1½ percent, according to Mr. Kingsley, on the employer, 1½ percent on the employee, and 1 percent more on the general taxpayer. I do not think that by any stretch of the imagination can be said to be insurance.

In the first place, insurance is a system by which you pay to spread your risk and you pay for the risk, what the risk is worth. Under this plan you do not pay with any relation to your risk.

You may take a family of five people and a man has an income, we will say, of $2,000, he will pay, he and his employer, for that insurance, $60.

On the other hand, a single man earning $4,800 will pay about $150 for a risk or service worth about one-fourth or one-fifth of what the other man gets for $60. It has no relation to insurance at all. Insurance is just a name.

To a certain extent it may be argued that these people are paying slightly in relation, some relation, to the services that they receive. However, I do not think even that is true, because the tax on the employer, without any question, is passed on in the price of the goods to the consumer of the goods ultimately, the consumer of the goods or services. It cannot be otherwise.

It is a tax and a fixed cost, and he cannot sell at less than cost. Ordinary economic operations hold the price above cost with a reasonable profit for those who are efficient and perhaps none at all for those who are not efficient, just on a basis of cost.

Senator PEPPER. How do you describe the old-age and survivors insurance plan now?

Senator TAFT. It is a tax for which we give free old-age pensions. It is somewhat related, again, to what you pay, but very distantly related. People who have been paying 1 percent in the last 10 years admittedly are not paying one-fifth of the actuarial value of what they are going to get from that benefit.

We threw away the whole actuarial basis 8 or 10 years ago and said that we could not carry that out in the national plan. It is a tax for which we give free service, and that is what this is. This is a tax. The Government would be taxing the people $6,000,000,000 a year and, in turn, giving them free medical service, just as they tax the people some such similar sum and give them free education. It is the same system.

Senator PEPPER. What does your bill do but tax the people and give them free medical service?

Senator TAFT. It does not give free medical service to those who can pay for it. S. 1679 is not insurance. The 1½ percent tax on the employee, I do not think even that is insurance because, as we have seen in the deductions from income tax in the pay-as-you-go plan, as we have seen from the pay-roll tax, the employees come to figure their salaries in take-home pay and their trading with the employer is based on take-home pay. In effect, the 1½ percent is passed over to the employer and by the employer is passed on to the consumer, so that as far as I can see, nobody gets anything for nothing. We levy taxes equal to about 4 percent of the pay roll or about $6,000,000,000, according to Mr. Kingsley, five billion eight, according to his estimate, which, of course, he does not purport to be a definite and certain figure—but all of that tax is reflected in the price of goods, and you pay for it through the increased price of goods; or, if you want to put it another way, in a decreased standard of living.

You pay for your medical care through the Government instead of paying directly. But the only point I want to make here is that it is not insurance. It is a tax which brings in five billion eight to the Federal Government, and then pays all the doctors in the country and the hospitals to give free medical service to all the people in the country, whether they can afford to pay for it or not.

I cannot see why the system must not be much more expensive, necessarily, in the end than the system that we now have because the very purpose is to provide a great many more services. Inevitably, you are going to have to pay the cost of those services. You may be able to reduce doctors' fees somewhat, but I do not believe the total amount of that would involve any very tremendous sum. Otherwise, there is no possible saving, and there certainly must be a general increase, which is a burden on the public. Nobody can tell what the expense may be.

May I point out that this insurance plan does not cover those who are unable to pay, does not cover the indigent, at least, because there is a kind of provision here to take care of it outside of the insurance fund altogether, and there is a suggestion that the social welfare bill over in the House may be substituted for that. But this particular bill, this particular plan, does not take care of the people who are most in need of medical care.

That is still a supplemental measure which is dealt with, I think, far more adequately in our particular bill. We estimate that cost will run up from 150,000,000 the first year to 300,000,000 at the end of 5 years. I assume under our treatment of the situation we would have more people probably than are included in the indigent class if and when the insurance operates because there will be a certain number of people who do draw a salary but their salary is inadequate, to pay for medical services.

Senator PEPPER. That is what impresses me. You surely cannot hope to accomplish your purpose set out on page 16, where you provide that the States shall set forth a State-wide program designed and calculated to provide within 5 years medical and hospital services without discrimination to all those families and individuals in the State unable to pay the whole cost thereof, without a Federal contribution for it in excess of $300,000,000 maximum.

Senator TAFT. I would not guarantee the 300,000,000 maximum, but you must remember I wholly dispute the fact that we are starting new. Seventy-five percent of these people or 80 percent are already getting medical service without any Federal aid. States are providing it.

Every general hospital in the United States is providing it. Doctors are giving free care to a certain extent. This is not new. If you match the $300,000,000 with about $300,000,000 from the States, that is $600,000,000, and add that to what is already being spent for free medical care to those unable to pay for it, I do not see why the $600,000,000 will not be reasonably adequate to take care of it. I would hate to guarantee the figures, because we are talking about uncertain costs.

Senator PEPPER. Did not the American Medical Association in 1939 say that 2 out of 3 of our people were unable to pay the cost of serious illness?

Senator TAFT. I do not know what they said, but if what they meant was that one year they might have a very heavy burden, that might be, but a large number of those people can take out insurance and will take out insurance, others are able to pay, I think. Some people believe in insurance and some people do not, though it has been sold pretty well to the American people. I think I would take out health insurance if I were starting a family, but I think if I were 40 or 45, I would quit taking it.

Senator PEPPER. I thought this ought to be made clear in the statement of issues involved, that S. 1679, the so-called national health insurance bill, with all of the disadvantages—and there are many—that can be said against it, I think it would first have to be admitted that it covers more people, that it is proposed to make available medical care to more.

Senator TAFT. Everybody.

Senator PEPPER. It does have the broadest coverage. I think you gentlemen should take one or the other horn of the dilemma. Either say the great masses of the people do not need help or you should tell them your plan is going to cost several billion dollars out of the Public Treasury if everybody needing help gets it.

Senator TAFT. That I would wholly deny. I do not know what the States are spending on this, but it must be 2 or 3 billion dollars. We are proposing to add $600,000,000 to fill up the gaps for those unable to pay.

In your proposal the difference, of course, is in the providing of free medical care to everybody. That is the socialization of medicine. That is what it means. The providing of free medical care to those unable to pay for it is not socialization. It never has been. We have always done it. Just as we provide relief to those unable to buy food, just as we propose to provide housing for those unable to provide housing. That is an effort to take care of people who are left behind in our general economic system, which I think on the average produces much the highest standard of living, but leaves a certain number of people behind.

That is one system, and that is the theory in which I believe, and that is what this bill is attempting to do. But when you attempt to give free medical service to everybody in the United States, most of whom are perfectly able to pay for it, then you are socializing medical service. If you are going to socialize medical service, I do not see why you should not gradually go on, it is a question of degree, of course, and provide food for everybody, provide clothing for everybody, provide housing for everybody. I do not see the difference.

Senator PEPPER. Now, the Senator has been making that statement for a long time, and it has colored the public thinking. Is it not a fact that under the Senator's bill a great many people will get assistance out of the public treasury who may not pay any tax at all into the public treasury; whereas, under S. 1679 every recipient is a taxpayer under that proposal, paying part of his regular income?

Senator TAFT. No. 1, the indigents do not pay anything. If you are going to take care of the indigents who do not pay anything in, that is not true. If not, your system would be defective in that it does not provide medical care for the very people who need it most, who do not pay anything in to the insurance fund, because they have no income or have not got the minimum necessary. That is the first one.

Senator PEPPER. Yours is the bill which proposes to give out of the public treasury in what I thought socialism meant, giving people something out of the public treasury without exacting any return from them, and that is exactly what you propose to do to the whole system of medical care where there is any benefit given by public authority.

Senator TAFT. That is what you do now. You do it in every city in the United States. There is not a city that has not got a general hospital where somebody unable to pay can get service.

Senator PEPPER. Then medicine is already socialized and you are going to make it more so.

Senator TAFT. That is not socialization, in my opinion. We have always provided for the poor. We do it in our county homes in this country, we take care of people in those homes who are unable to take care of themselves——

Senator PEPPER. That is nearer socialization than insurance.

Senator TAFT. You do not have necessarily a choice between the two. You have, as I see it, a free-enterprise system, the very basis of which is incentive, payment for the value of the work that you do. That system, I think, has increased our production and our standard of living more than that in any other country in the world.

Senator PEPPER. We agree to that.

Senator TAFT. But since it is based on that, you will have a certain proportion of the people who fall behind, either because they cannot work, are not able to get work, will not work; perhaps they are working and making things that people just will not pay enough for so they can get a living wage out of it; and to say that a free-enterprise system which proposes that you take those people and put a floor so that they have a minimum decent living is socialism, I think, is a misuse of the term. I do not think it is socialism.

I think that is charity, if you want to call it that, Government charity, if you want to call it that, but I feel very strongly that it is an essential and proper part of a free-enterprise system, as in contrast to socialism.

When you provide a free service to everybody in the United States out of the Government Treasury, that is socializing that activity, and you have socialized a few. You have socialized primary and secondary education. It is socialized today. It is provided out of taxes to anybody who wants to come and get it, whether they can afford to pay for it or not. That is true. We did that 100 years ago.

The Post Office is a socialized business today. But I object to extending that socializing principle into the providing of medical care.

Senator PEPPER. Yet that is what you are doing. You are proposing out of the Federal Treasury, State, and local, to give the medical services to those who cannot pay for them at all and to give the difference between what they can pay and what the services cost.

Senator TAFT. I do not think there is any use arguing or repeating my argument. I do not think I can state more clearly the position I have stated. I stand on that.

Senator PEPPER. I wanted you to have an opportunity to answer that. I say this, and it is my honest observation on your measure: With all the great virtue it has, you are either forced to the logical necessity of saying, "We are only going to help the people in the lower income brackets or in the admittedly indigent class"—and I had understood before you had said there were about 20 percent of the people who could not pay for medical costs and you were going to try to help those people. That is perfectly consistent with our traditions and our past practices.

But that ought not to be sold to the American people as a plan that will provide adequate medical care to everybody in this country.

Senator TAFT. My general proposition is that if you increase your doctors and facilities and public health, that the medical care will be availabe to those who can pay for it with entire adequacy. I think practically it is available today with adequacy. But I think it can undoubtedly be improved, and I think also that you can meet this particular problem of emergency catastrophe illness by making available voluntary insurance to everybody who wants to take it out.

Senator PEPPER. The other thing is when you pass above the 10 percent or 20 percent, I think there are about 10,000,000 people in the country who make less than a thousand dollars a year, you would have to include all those people and, I suppose, everybody who makes less than $2,000 a year.

Senator TAFT. I think your figures are obsolete today, Senator. Those income figures have all changed and, in the second place, they are not very satisfactory. It is hard to tell what they are.

Senator PEPPER. When you get above the admittedly indigent class in the case of catastrophic illness that comes to beset a family or an individual, you are going to have to give, if you carry out your objective here, you are going to have to give assistance out of the Federal Treasury, State and National Treasuries, too, I would say, at least two-thirds of the people of this country, if they are going to get—if not more than two-thirds, and that is going to cost a large sum of money from the Federal Treasury.

Senator TAFT. Yesterday Mr. Kingsley made the statement that half of the families, that the average income was $3,000. That may be high.

There are about 35 million families, so that you have got 17½ million above that, I think probably a $2,000 family can buy insurance, if they want to do it that way. I think you will find that my figure of 20 percent is not far wrong.

Now, I would be perfectly willing to admit, that you have, perhaps, an additional group of people who, by reason of a catastrophic illness or accumulated illness in a family, become unable to pay and are added to the group that would ordinarily be counted, so you would add 5 percent more. It might be 25 percent of the population.

Senator PEPPER. You take the fellow I know around this Capitol, he is having to sell his home in order to provide medical care for the illness of his mother. What are you going to do about him? That fellow is working and yet he has got to sell his home. Has he got to sell every bond he saved during the wartime? Does he have to borrow all the money he can borrow, sell his automobile or not buy a radio?

Senator TAFT. In regard to the people with not enough money to live on, we do not know how big a group that is, although I am suggesting it is not over 20 percent. Suppose 20 percent of the families, or around 9,000,000 families, suppose it cost you on an average about $100 a year, which is what seems to be the basis of your cost, that is $900,000,000 for that purpose.

This bill provides $600,000,000, and we are already spending a good deal more than that, the States are already spending a lot more than that. I would suggest that the $300,000,000 we are providing here is probably sufficient to fill up the gaps in the failure of the localities today to provide medical service for those unable to pay.

I do not admit that this is in any way an inadequate sum. I cannot guarantee it because, as you know, the costs under the British Government plan, which Government adopted your plan, in effect, the cost was 60 percent more than they planned. They had to increase the budget 60 percent.

Senator PEPPER. Because people rushed in to get dental and medical care they never had a chance to get before. That is the reason.

Senator TAFT. I have a letter from an English doctor that I thought was rather interesting on that subject. I do not know whether the Senator would care to have me read it.

Senator PEPPER. I would be glad to have you do so. I might want to get some testimony from the English patients.

Senator TAFT. It is from a doctor in St. Lawrence's Hospital, Caterham, Surrey, dated April 12, 1949, addressed to me. I do not feel that I should give his name. It reads:

> I am of course a stranger to you. My only excuse for seeming to interfere in the future policies of the United States is that I spent by childhood and college life in and around Boston, Mass., up to the Presidency of your esteemed father.
>
> I am a physician and I wish to do what little I can to warn the people of the United States to avoid a national health service as it has prostituted medicine in Great Britain. The poor public has been converted into hypochondriacs en masse and it was bad enough prior to July 5, 1948, but now it is terrible.
>
> Doctors' waiting rooms are packed with Britishers and foreigners waiting for a bottle of Epsom salts, cheap iron tonics and cough mixtures, false hair, spectacles, false dentures, and some chemists are persuaded to substitute beauty preparations for prescriptions.
>
> The above is not, however, the worst. This service has led to a marked determination in the treatment of the sick people—the doctor who is paid about $4 a year for each person is so busy that he has no time to examine them.
>
> It is not a question of stripping the patient to the skin—the patients now are either not examined at all or are examined with their overcoats on.
>
> But in reality this does not worry the average patient. A visit to the panel doctor becomes almost automatic and he wastes up to 4 hours waiting for his turn and usually demands his favorite bottle of medicine.
>
> Thus the doctor has deteriorated to being the patient's obedient clerk. Millions of dollars are wasted every year in useless and cheap medicine which is a danger to the public and a source of income for the drug store.
>
> This is paid for by a compulsory levy of $1.25 a week. When the patient is too sick to work he gets $6.25 a week which is not sufficient to pay for a furnished room of a very low standard over here. A very ridiculous sum; if a commercial insurance company charged the same the patient would receive $35 a week for 11 months and $15 per week indefinitely afterwards.
>
> I would be pleased to help to fight this impending injustice in the United States.

I had not intended to put that in, but you asked for it.

Senator PEPPER. I am glad to have it. That doctor did not add what income he was making, did he? Since we at this table, you and your distinguished colleague, we are not entirely insensible to political considerations, we might be interested in knowing that the conservative government has not dared to attempt to repeal or advocate the repeal of that system, and recently there was a member of the House of Commons belonging to the Labor Party, a labor lord, who was here, and a member of the Conservative Party, who is not at all in sympathy with the general program of the Labor Party, all three told us that the health legislation in England did more to win for the Labor Party a recent election in a conservative middle-class constituency than anything else they had to rely upon in that election.

Senator TAFT. I notice the Labor Party, however, suffered rather a serious set-back in two recent local elections. Possibly the people may have changed their minds.

Senator PEPPER. This was a parliamentary election and this was a middle-class constituency. The people are getting something they had never been able to get before.

Senator HUMPHREY. Was it not Mr. Churchill who said he really was the father of this plan?

Senator MURRAY. That is what the Conservatives complain about. They complain the Laborites are trying to take it away from them.

Senator TAFT. Secondly, I have tried to contrast the fact that this is national medicine, as against local and State control, this is Government medicine as against the existing system, which I believe has been a successful system on which we should work for improvement. It is Government medicine because the Government does supply it. I do not know what system may finally be adopted.

Either you have to have payment by service—apparently that is extremely expensive, it has been found to be so in New Zealand. You would have to have a tremendous body of clerks to keep count of about 70,000,000 different medical services every year in the United States. If you find that too expensive, then you pass, perhaps, to a panel system, a per capita system, in which a certain number of patients, some hundreds of patients, are assigned to every doctor and go through on a perfectly automatic basis.

I do not believe the GI's—and this is no reflection on the medical service of the Army and Navy—but the GI's that I have talked to who got medical treatment, apart from the battle care, which, of course, was exceptional, but their ordinary response to the Government doctors who examined them in a panel system was certainly exceedingly unfavorable. I do not think any of them felt they were getting any real personal consideration whatever.

I think the result of the system is bound ultimately to lead to a salaried doctor force, and if you are going to have Government medicine, I think you might just as well admit that you have to put the doctors on a salary much as school teachers have been on a salary.

Incidentally, even in schools, which I said are socialized, we have never undertaken to do it on a Federal basis.

The International Labor Office, which is the principal international proponent of sickness insurance, admits this insurance is not really insurance and will not remain so for long. In their book entitled "Approaches to Social Security," they say this:

> The fact is that once the whole employed population, wives and children included, is brought within the scope of compulsory sickness insurance, the great majority of doctors, dentists, nurses, and hospitals find themselves engaged in the insurance medical service, which squeezes out most of the private practice on the one hand, and most of the medical care hitherto given by the public assistance authorities, on the other. The next step to a single national medical service is a short one—

I think inevitably what we are proposing here at a cost of $5,600,000,000 a year or more is the providing of free Government medicine, free medical service, through Government employees. I cannot see any outcome to it except ultimately the direct employment of all doctors on a salary who are engaged in this particular work.

There will, of course, remain a certain number of doctors outside who will be sought by people who are willing to pay for their services over and above what they pay in taxes for the general medical provision.

So that in general our bill is based on the theory that we take the present system, which has been a successful system, we fill up the gaps, try to improve it in every way, and that we spend a tremendous amount of our energy in improving the public health services and in preventive medicine. I do not think we should throw away a successful American system and begin all over again on a new kind of medical system which has not, at least up to date, proved to be a success, has not had any proven success in any country in the world.

That is my statement.

Senator PEPPER. You would not exactly say this is free if these folks all put up the basic part of the money for it, would you?

Senator TAFT. I have tried to make my point that this is not insurance. This is a tax of $5,600,000,000, which they pay and which, incidentally, they are going to pay in a different proportion from their wages because they are going to pay it in the increased cost of goods and services they have to buy.

We have already got our tax burden up to $40,000,000,000, and if we add here $6,000,000,000 more, making $46,000,000,000, that simply increases the burden on the economic machine, and that machine adds that burden on to the cost of the goods, and the people pay more for the goods and services which they get.

They pay most of these taxes not directly but finally in the cost of the goods and services they buy, and the only kind of tax that is not paid that way, in my opinion, is the corporation profit tax and an individual tax over and above perhaps five or ten thousand a year. Those taxes are probably not passed on, but the ordinary type of pay-roll deduction, whether an income tax or otherwise, and, of course, all of the excise taxes clearly, in my opinion, are passed on in the price of goods.

Senator PEPPER. You do not advocate or never have advocated repeal of the present old-age and survivors insurance?

Senator TAFT. No, but I would rewrite the whole thing, and I would be in favor, I think, under the present system of fixing it at a low rate and then making available a voluntary system to everybody who wanted to go above that, to integrate with that all of these other plans that are set up by this company and that company or by this union and that union. The whole subject ought to be, in my opinion, completely reconsidered, and I hope the Congress may do it.

I do not think you can go back. These people have acquired a vested right to a certain extent, although it may not be for the full amount of their pension, but they have certainly paid in some money on the books, and it is pretty hard to go back.

But I do think it ought to be a kind of a basic underlying payment and then, as I say, integrated with all of these pension plans, et cetera, that we are setting up in so many different ways, plus the possibility through voluntary action for any individual who wants to, to add to that.

Senator PEPPER. Is there any outstanding difference between your proposal and 1679? If a person wants to get medical or hospital or dental care under your bill and he wants to get Public Health to pay the bill, he has to satisfy some social worker or what some would call a bureaucrat as to his inability to pay, and he has got to make a disclosure about all that he has got and all that sort of thing and all he can make. There are a lot of people who do not like to come in and say they are either paupers or to a degree incapable of paying their bill.

Senator TAFT. This is an attack on the so-called means test.

Senator PEPPER. I know it, but if the Senator will let me present the other, that is what everybody has to do who gets any benefit under your bill; whereas, under 1679, he has his income, he may be self-employed, then he becomes entitled by virtue of having made those payments, and the poorest person who is employed gainfully by paying a percentage of what he makes is brought within the system, he is freed of the ignominy of having to meet the means test. Those distinctions do exist, do they not?

Senator TAFT. No, because, No. 1, your system does not take care of your indigent. The indigent have to go in and take a means test to prove they have not any money.

Senator PEPPER. That is somebody who is not employed.

Senator TAFT. Yes, but they have to go in and take that test.

Senator PEPPER. We separate those people. They are not in this bill.

Senator TAFT. The second thing is this: What is this means test? We have it in every provision for taking care of people who are not able to pay for what they get. We have it in housing and it is not any longer a difficult thing. Practically everybody pays an income tax. What it amounts to today is: What is your income? What are your wages? That is the extent of the means test in housing, that is the extent of the means test practically in any field today.

You do not have that kind of searching examination that social workers used to give under the relief program. It is a question which is perfectly acertainable today: What is your income? If you have a lot of stocks and bonds, I suppose they might ask about that, but the whole question is: What is your salary? What did you get in the past year?

He has already made a return to the Federal Government. He has already deducted for his income tax or, at least, had the figures available so he can see if he is subject to income tax. That is a perfectly ascertainable figure as to what a man's income is today. That is what we base our housing on. Everybody who goes into public housing has to give those figures. They are not humiliated. All they have to do is go in and say, "I am employed by so-and-so, and these are my wages."

Senator PEPPER. If that is the criterion, why not tell the American people that your proposal purposes to give help to everybody making less than $2,500 a year or making less than $2,000?

Senator TAFT. That is not the rule. There would be different rules in different places, different rules in different States. It would be a test gradually worked out.

I certainly would not want to prescribe a national figure any more than in housing. One of the big objections of the real estate interests is that they want a national figure. We said every State and every city is different, as is the case here.

Senator PEPPER. You agree that the one who pays the tax, whatever you call it, under 1679 does not have to be subject to a means test by a social worker or a bureaucrat?

Senator TAFT. No, and neither does anybody else. This means test is just a red herring, that is all it is. It is something which is at the base of our entire aid to those who are unable to pay, our aid in relief, our aid in housing, our aid in medical care today. You have the same thing in every general hospital in the United States today.

There is not a hospital—they have to take everybody who comes in and they ask him: "Can you pay for this service or not? What wages are you getting?" They are asked that in every general hospital under present conditions, and I have not heard the slightest complaint.

Senator HUMPHREY. I have heard a good many of them.

Senator PEPPER. So have I.

Senator HUMPHREY. I was chairman of a general hospital which spent about $5,000,000 a year, and that was a No. 1 problem.

Senator TAFT. Usually when they have money, they do not want to pay anything toward the cost.

Senator HUMPHREY. Is it not true that the degree of indigency is always variable?

Senator TAFT. Yes.

Senator HUMPHREY. Let us say, for example, under your plan you would have someone classified as not being an indigent at the moment, but a little later this person may become ill and may become an indigent during the period of illness.

Senator TAFT. That is right.

Senator HUMPHREY. So you do have this flexibility all the time as to just where the lines are for the application of your particular plan.

Senator TAFT. Now, in the District of Columbia every child is examined for dental health and, I am told, a child gets free dental care if the principal certifies that his parents are unable to pay for dental care.

I do not hear any complaint. Probably it is loosely and not exactly administered, but it reaches a rough justice.

Senator HUMPHREY. It seems to me that so far as your plan is concerned——

Senator TAFT. You have a choice. Either you have a means test or you give your service free to all people in the United States, and that means that instead of costing, I would say, one billion two for free medical care, you are going to have to pay five billion six, plus a lot of State assistance.

In other words, you have the choice between socializing the service and adopting a means test, one or the other.

Senator HUMPHREY. I would like to just make one or two observations about it because I am not in opposition to your plan as far as it goes.

I think the real argument is whether or not this is an adequate extension of medical care to meet the health needs of our people.

Senator TAFT. I agree, that is the question, because your plan does not take care of the indigent, either. You have got to impose a means test there.

Senator HUMPHREY. The means test has already been imposed by the social agency which certifies them as being available for the insurance plan.

I would like to go back to one point. Just, as you said, the means test is a red flag that is waved around at times, so I think there are other things that have been said here that are red flags. It would be good to get them cleared up.

For example, the term "Government medicine." Now, under the proposal of the national health insurance program the medicine is not Government medicine, the medicine is free medicine, private medicine, it is administered by private doctors, it is administered in the Presbyterian hospital, or Catholic hospital, or Baptist hospital.

Senator TAFT. It is paid for by the Government.

Senator HUMPHREY. It is paid for by the people.

Senator TAFT. No; by the Government. The Government pays for it and the Government furnishes that service, and somebody in Washington makes all the regulations saying what you are entitled to, whether you are entitled to an X-ray in this case or that case, whether you are entitled to penicillin for this disease or that disease.

Senator HUMPHREY. That is not the case, you know.

Senator TAFT. That is the case in England. Those are the regulations in England.

Senator HUMPHREY. This is the United States of America, and the bill, S. 1679, provides for local use and for local regulations as to the extent of medical care.

Senator TAFT. No; it does not.

Senator HUMPHREY. And the practice of medical——

Senator TAFT. It does not. You find it does nothing of the kind. The regulations are made by the National Board and the State administrators have nothing to do except comply with the regulations of the National Board.

Senator HUMPHREY. The matter of health standards and the cost of payment are determined by local boards.

Senator TAFT. Not at all.

Senator HUMPHREY. Only administrative regulations which pertain to the use of the money and to the payment of the money are made by the national office, and I think that ought to be crystal clear.

One other thing I want to point out: We need a definition of the word "socialism." I have heard this word "socialism" kicked around. What is the orthodox meaning of "socialism"?

It is not what we have been talking about here this morning. It is state ownership of the means of production and distribution. That is basic, elementary economics from Garver and Hansen, textbook, Economics No. 1.

Now, if there is any socialized medicine in this country, it is to be found in a municipal hospital. If there is any socialized medicine, it is in a State hospital or in a university hospital. If there is any other socialized medicine to be found, it is to be found in the veterans' hospitals.

Senator TAFT. I do not agree at all.

Senator HUMPHREY. Whether you agree or not, the point is the economists define socialism as state ownership of the means of production and distribution.

Senator TAFT. But no one can question the fact—and I do not use socialism as a term of approbrium—socialism is entirely justified in many fields, and socialism, if the Government undertakes to levy all the taxes and furnish free educational service, then they have socialized education.

Senator HUMPHREY. They hire the teachers and they own the buildings, they own the means of production and the means of distribution. Under this program they do not hire the doctors, nor do they own the hospitals or the drug stores.

Senator TAFT. Under your program they do hire the doctors and they own many of the hospitals, and they can employ private hospitals, if they wish to do so, and should, of course, because the system has been built up as a part private, part public, system.

Senator HUMPHREY. This program does not provide for the Government ownership of hospitals. It does not provide for the Government hiring of the doctors.

Senator TAFT. But it provides for the Government paying——

Senator HUMPHREY. Money for paying hospitals and doctors.

Senator TAFT. It provides for the Government paying everybody's hospital bill and, therefore, it socializes the furnishing of medical service.

Senator MURRAY. Please speak one at a time.

Senator TAFT. We are arguing about words, and they do not mean so much. I do not think there can be any question that this is the socialization of medicine and also the nationalization of medicine. Whether this is desirable or not, that is a perfectly legitimate argument, but that is what it is.

I say I am not objecting to the fact that primary and secondary education has been socialized; I am not proposing to desocialize it, and there is a perfectly good argument for socializing medicine, if you want to, but that is what it is, and I do not happen to agree with that argument.

I think the present system, based on——

Senator HUMPHREY. When we discussed Federal aid to education, there was testimony that in the State of Vermont there were certain private academies and that under the Federal aid to education bill this money would, through the State department of education, go to those private academies.

Are you going to say to me that those private academies, supported by tax funds, are the same thing as a public-school system where the teachers are hired by the State department of education, where the buildings are owned by the local board of education? We made a differential.

Senator TAFT. Of course, it is not the same thing, but, on the other hand, that education in those schools is furnished free to those children by the State of Vermont and, therefore, their education is socialized to that extent, at least. I suppose the actual ownership of the school may make it more extreme socialism than otherwise.

Senator HUMPHREY. I would like to ask this as a sort of series of alternatives or set of alternatives.

Let us assume that every single person in the United States, by some magic, took out a policy with Metropolitan Life Insurance Co. for complete hospital and medical care. Would that be bad?

Senator TAFT. I beg your pardon?

Senator HUMPHREY. If every one here in the country, every family, took out a policy for complete hospital and medical care from one of the large life-insurance companies, would that be bad?

Senator TAFT. I think it would be a great mistake.

Senator HUMPHREY. I am happy to hear your point of view on it. I think it would be quite wonderful if the cost were not too much.

Senator TAFT. I think there is a very good basis for health insurance, for voluntary insurance, in a large group of population, but I would say not all of them.

Senator HUMPHREY. Of course, this plan provides for about 85,000,000 people.

Senator TAFT. This interests me. What do you cover? I suppose I probably have had less trouble than most. Usually I have to go to doctors for colds. Well, why should the Government furnish me with free medical service for colds? I would have been just as well off if I had gone to bed and not gone to a doctor in every case.

Senator HUMPHREY. You may be right.

Senator TAFT. I do not think you get anything except possibly you satisfy yourself and make yourself feel better for a while. Why should the Government undertake to provide that to me free? I do not see it, and I do not see why I should buy insurance to have that provided free because that is what the insurance rates would be based on: The fact that a lot of people do want to do that and go when it is not necessary to go.

I think it would be unfortunate to have everybody in the United States take out voluntary insurance, because there are a lot of people who find it much cheaper not to do it.

Senator MURRAY. Senator, I took out health and accident insurance about 40 years ago and carried it until I got to be 65, and then discontinued it.

Senator TAFT. I took out a disability insurance policy when I was a fairly young man, and I was paying $170 a year and have been ever since and never got a cent back.

Senator MURRAY. That is the kick I had.

Senator TAFT. I go to the point where it was going to run out, too. That is all right. I think probably at the time it was justified, but if I had not taken it out until I was 40 or 45 years old, it would have been a mistake.

Senator HUMPHREY. You used the term "free medicine." What do you mean by "free medicine"? When you are collecting $6,000,000,000 in taxes, it is not very free, is it?

Senator TAFT. You pay for it through taxes.

Senator HUMPHREY. It is not free medicine.

Senator TAFT. It is free to a particular fellow. He has not necessarily paid any taxes or the equivalent of what he is receiving. It has no relation to what he is paying.

Senator HUMPHREY. It obviously cannot be completely free to him.

Senator TAFT. The people as a whole are not getting one dollar's worth for nothing. That is perfectly true. They all pay for it.

Senator HUMPHREY. Is not that rather true today?

Senator TAFT. Nevertheless, from the point of view of this man sitting here, he can go to any doctor and, without paying another cent, under this system he can get free medical care without paying for it. That seems to me to be free medicine.

Senator HUMPHREY. If he is employed, he does make a payment.

Senator TAFT. He makes a payment whether he goes and gets medicine or not. He is taxed so much money.

Senator HUMPHREY. Just like public schools. He is taxed whether he has children or not.

Senator TAFT. He has the right, if he wants to, to go and get medical care for nothing.

Senator HUMPHREY. That is hardly a correct statement; is it?

Senator TAFT. That is absolutely correct.

Senator HUMPHREY. We will say a man is earning $2,000 a year, he may not be ill for 15 years, but he has paid in his money, and he gets the medical care because he has been paying, not for nothing.

Senator TAFT. That is the difference between taxation and paying for things. If you pay for things, you pay for the thing you buy at the time you buy it. If you are taxed, you pay for it in taxes. But as far as providing that particular service, it is free at the time it is provided. You can take it or not, and you do not pay a cent for it, and that influences a lot of people to go and get it free and if they had to pay for it they would never go and get it. That is why you have had the tremendous run on the doctors in England.

To go back to the question in regard to the regulations, 1679, page 107, says that this National Board—

> may by regulation limit for a specified period the services which may be provided as benefits, or modify the extent to which, or the circumstances under which, they will be provided to eligible individuals.

It is absolutely necessary, if you are not going to have the expense run away with you, to limit that service, to say that a doctor cannot prescribe a very expensive medicine except in certain cases, just as the British Government does today. It is bound to be. You have got that problem. You have got the problem right now of the fiscal officers in the British Government telling the hospitals that they cannot have so much money next year. He cannot afford to give it to them, they have to cut down this or that service and change the regulations.

I do not know whether they will provide free toupees and free eyeglasses or not, but those things are all going to be the subject of national regulation under this bill, and every State and every local officer is going to have to be bound by it.

Senator HUMPHREY. The reason for that is to eliminate abuses.

Senator TAFT. You have got to do it. That does not change the fact that you do it and that you have a completely regulated national system.

Senator HUMPHREY. They surely regulate the kind of medicine that you are talking about. If you have ever spent 1 day or 1 hour in a general hospital, you know there are all kinds of regulations as to the kind of services that are offered.

Senator TAFT. Yes.

Senator HUMPHREY. There are such regulations as: You do not use seconal, which is a barbiturate; you use plain veronal at one-tenth the price.

Senator TAFT. Those are the problems in giving free service. If you pay for it, you get what you want.

Senator HUMPHREY. May I say that even in the best hospitals you get that kind of regulation. You have standard medical practice in the best hospitals. I spent a good share of my life selling prescriptions, and I can assure you I have some idea about the kind of medical care that is offered in even the best hospitals.

Senator MURRAY. What I am afraid of is that under your bill, if you are going to provide socialized medicine for 20 percent of the people, that the other 80 percent, observing that situation, are going to begin to demand that socialized medicine be extended to the rest.

Senator TAFT. One great trouble about all welfare service is that you may gradually lead the people to think the Government should support them all and to pay all their expenses. If you get to that point, you have lost the whole system of liberty in the United States, because when the Government supports them all, it will tell them how to live, and that is the reason I am opposed to extending it further than we have already.

We have extended it pretty far already. In a way we are now taxing about 25 percent of the people's income, and to that extent we have taken away their freedom, and they have got 75 percent of it left, to spend their money the way they want to spend it. I hate to see the taxes go further in any substantial amount.

I think we can afford $300,000,000 for this job and probably, I would say, in health, housing, and education that for $2,000,000,000 you can fill up and improve the present system to a tremendous degree and that in the course of 10 years it may get up to that figure, that is, the Federal assistance. Of course, already the States are spending much more than that on those three services. We hope, of course, that the Federal Government may get rid of these foreign expenses; $22,000,000,000 out of the $42,000,000,000 is for the Army and ECA, just those two things take more than half the total Federal budget; and there is reasonable hope that with restoration of peace in the world, you can get that 22½ down to 11, for instance, and if you can then expand your welfare services a couple of billion dollars for health, education, and housing, or do it before in coincidence with a decrease in military expense, I think you will have a tax burden you can reasonably bear and still keep the incentive alive that increases the production and employment.

Senator MURRAY. I think, Senator, that the other 60 or 80 percent of the people who will be observing this socialized medicine that you are providing are going to move in and demand that it be extended to the country.

Senator TAFT. You may be right, but that does not make the demand right.

Senator MURRAY. Already the labor organizations of the country are beginning to demand that their health be taken care of and the health of their families through increased wages and provisions for health and security, so that it does seem to me that our bill is the more reasonable bill, the bill that is going to provide a system of medical care in which the people pay for it.

Are there any other questions?

Senator HUMPHREY. I do think, Senator, that a pay-roll tax is a restriction and is an impediment to the ever-increasing demands of people for more and more services.

Where you can take a lump sum out of the General Treasury, there is no doubt in my mind that is a greater inducement to people thinking they do not have to pay for it, but when they see it deducted from their check every week, they know they are paying for medical care.

Senator TAFT. They go in at the time of the next bargaining settlement and make the employer pay that much more, and they usually will. He has to look at it as take-home pay, just as they do.

Senator MURRAY. Does that conclude your statement?

Senator TAFT. Yes, sir.

Senator MURRAY. Thank you for your very able statement.

We will hear next from Senator Hill and Mr. Bugbee.

STATEMENT OF HON. LISTER HILL, UNITED STATES SENATOR FROM THE STATE OF ALABAMA, ACCOMPANIED BY GEORGE BUGBEE, EXECUTIVE DIRECTOR, AMERICAN HOSPITAL ASSOCIATION

Senator HILL. I would like to say that I have with me here this morning Mr. George Bugbee, the executive director of the American Hospital Association, who has made a great contribution in the drafting and the work on this bill that I shall discuss.

Mr. Chairman and members of the committee:

Through the Senate Committee on Labor and Public Welfare, of which we are all members, the Senate and the Congress of the United States can have the opportunity to enact legislation and do more for the health of the American people than any Congress in our history.

Upon us rests the responsibility to give the Senate a legislative program that can be put into operation promptly and effectively and meet the urgent health needs of the Nation.

We can give recognition to the importance and complexity of the health problems of our modern industrial civilization by creating a Federal Department of Health and Welfare. The Secretary of Health and Welfare would give new direction and new coordination to the functions of our Federal agencies for health. He would provide the leadership and speak with the authority of a member of the President's Cabinet.

With the passage of the Hospital Survey and Construction Act of 1946, the Nation undertook for the first time a Nation-wide program of planned and coordinated hospital construction. Today nearly 800 hospitals, health centers, nurse homes and other hospital facilities are being built or have been approved for construction under the act.

Recent hearings on S. 614 to amend that act, held by the subcommittee of which I am chairman, have revealed that even this program of construction must be enlarged to meet the need for hospitals and health centers. Unless the program is enlarged Federal participation will not keep pace with the rapidly expanding programs of the States. Our subcommittee plans within the next few days to submit to the full committee a favorable report on S. 614 to double the amount of Federal aid, increase the aid to individual projects and permit the States to channel greater aid into their low-income or rural counties and communities.

Preventive medicine through the public health services is a basic part of any modern health program. Yet last year some 40,000,000 Americans had no public health service. Another 85,000,000 had only doubtful protection from inadequately financed and understaffed health units. And only 10,000,000 of our 146,000,000 people had the protection of full-time, professional health departments.

Hearings on S. 522, the bill to provide increased Federal aid to local public health units which our subcommittee plans to report favorably within the next few days, have convinced the members of our subcommittee that the ramparts of national health begin in the local health offices. Yet only 1 in 10 of the local health offices is staffed and financed to carry on a reasonably adequate program. The strategic and vital importance of local health offices to the Nation's health was emphasized at our hearings by Dr. James E. Perkins, managing director of the National Tuberculosis Association. Dr. Perkins declared:

> The National Tuberculosis Association has long held the opinion that effective tuberculosis control can be achieved only if there are adequately staffed and adequately financed full-time local health services. We know enough about tuberculosis today to rid our Nation of the disease if there were local health officers and public nurses in the field to follow up each case and assure treatment. The chief function of our association is educational. But education falls down if there are no X-ray machines and other facilities and not enough people in the local health agencies to actually do the work.

The Senate, as we know, already has passed and sent to the House the school health services bill reported by our committee, the Committee on Labor and Public Welfare, which provides for medical and dental examinations for every school child and, in some cases, medical and dental treatment. Through this measure and S. 522, the local public health services bill, we can carry to the grass roots—farm and cross-roads, town and city—protection against tuberculosis, malaria, typhoid and undulant fever, syphilis, infantile paralysis, and the epidemic diseases. We can discover and correct many of the physical defects and ailments in our children at the all-important school age.

Medical research is health protection for tomorrow. The medical colleges, the privately-endowed foundations, and many private industries are carrying on great research work. The Federal Government is lending its support to research through the National Institute of Health, the National Heart Institute, the National Institute of Dental Research, the National Mental Health Act and the Atomic Energy Commission. I think we ought to go forward and in many other fields that is a challenge for the Federal Government to help and do research work.

The Senate Committee on Labor and Public Welfare reported to the floor and guided through the Senate the National Science Foundation bill. This bill must be passed by the House and signed by the President, and provide a single agency for correlating and coordinating the vast research of the Nation.

The success of our health programs is ultimately dependent upon the training and experience and qualifications of the people who direct the programs. The finest hospitals and health centers, the ultimate in medical knowledge are useless without doctors and nurse and trained workers.

America is suffering a manpower shortage in the field of health. There are less than 200,000 active physicians for a population of some 146,000,000 people. The shortage of dentists, nurses, technicians, and public-health workers is equally as serious. I strongly urge a comprehensive program and this committee has before it as one title in this bill that matter, and I hope they will bring forth a separate bill on this question of Federal aid for scholarships, for grants to the schools and colleges for additional teachers, and grants to the States for expansion and construction of medical schools to train the doctors, dentists, nurses, sanitary engineers, technicians and health workers of all kinds that are so badly needed.

Surely, as the Senator from Ohio said in his statement, a bill of this character should be reported to the Senate by this committee so that the Senate can act on it in this session of Congress, looking to its enactment at this session of Congress.

Our committee should not forget that the underlying foundation of the health of any nation is the soil and the food we obtain from the soil. I believe the committee will agree that an essential part of any health program must be steps to restore and maintain the health-giving minerals and nutrients of the soil—the objective of the national soil fertility bill, which some of use are sponsoring in the Senate.

There is a further step necessary to a comprehensive program of health for the American people—the provisions of adequate hospital and medical care for the individual.

This is the objective of S. 1456, the voluntary health insurance bill sponsored by myself and Senators O'Conor, of Maryland; Withers, of Kentucky; Aiken, of Vermont; and Morse, of Oregon. You are familiar with the Hospital Survey and Construction Act and its program. The voluntary health insurance bill will perform the same initial service in providing hospital and medical care that the Hospital Survey and Construction Act is now providing in the building of hospitals and health centers.

The bill will not do this through a strange and untried system of compulsion. The bill strengthens and builds upon our existing medical institutions—the tried and tested methods of American medical practice and the voluntary prepayment health insurance plans which more than a third of our people have found effective and trustworthy.

The sponsors of the bill believe that the present system of medical care has been too valuable, too effective and too useful through the years to throw it aside for a new system which might not work. We very sharply disagree with the statement of Mr. Kingsley yesterday that this present system is totally inadequate for the American people. We believe it is the course of wisdom first to examine our existing health and hospital and medical resources. Then to strengthen and build upon them. This the bill will do.

The purpose of S. 1456 is to bring adequate hospital and medical care within the reach of every American through the system of voluntary participation in prepayment health insurance plans. The bill will provide Government supported membership in health insurance plan for those who cannot pay. It will stimulate and encourage participation by self-supporting persons. It provides for surveys which will be the basis for programs to meet the shortage of doctors, especially in rural areas, and to determine the need for additional diagnostic facilities and the need for additional facilities for treatment of mental illness, tuberculosis, and chronic diseases.

The Federal phases of the program will be administered by the Surgeon General of the United States Public Health Service. Within 6 months after enactment of the bill the Surgeon General shall issue broad regulations—these are broad regulations such as we have today under the Hospital Survey and Construction Act, and the committee knows these are really broad, laying down broad policies, with the real control and administration in the hands of the States. These broad regulations establish:

The general standards of eligibility of persons unable to pay subscription charges for health insurance.

The general types of hospital and medical care to be provided under the program.

The general standards for participation by voluntary prepayment plans.

The general standards for participation by nonprofit prepayment plans.

The general methods of encouraging and assisting in popular enrollment in the prepayment plans within the States.

A Federal Hospital and Medical Care Council composed of 10 persons—2 doctors, 2 hospital administrators, 2 prepayment plan officials, 4 representatives of consumers—will share responsibility with the Surgeon General in developing these broad policies of the program.

In the States the program will be administered by a State agency, which may be the same agency now administering the hospital survey and construction program in the State. This agency will have a council with representation similar to that of the Federal Hospital and Medical Care Council.

Within the States—and I want to emphasize this—regions will be designated in which complete hospital and medical services should be made available. In many cases these regions already have been estblished under the operation of the Hospital Survey and Construction Act. Within each region a Hospital and Medical Care Authority will operate as a unit of the State agency. The regional authority will be composed of persons residing within the region and shall include representation from as broad a segment of the population as possible. The regional authority will encourage coordination of all health facilities and services in the region and will recommend means for their effective use in serving the areas.

I cannot overemphasize that matter of coordination. As Senator Taft recalls, we had testimony as to what has been done in Rochester, N. Y., and that area in the coordination of hospitals and facilities in and around that outlying area. We also had testimony about certain coordination down in North Carolina, all of which was most interesting and challenging, showing what can be done if you tie those hospitals, those diagnostic facilities, the clinics, and these other facilities together so as to provide a well-rounded medical-care program available for all the people.

The voluntary health insurance program will be financed through Federal funds and a variable percentage of funds provided from State and local sources under the formula used in the Hospital Survey and Construction Act. This formula allocates a greater percentage of Federal funds to the States with lower per capita income.

The immediate aim of S. 1456 is to provide protection for people of limited income by giving them service cards in voluntary prepayment plans which will entitle them to the same kind of hospital and medical care as those who are able to purchase such protection on a voluntary basis.

The plan has three advantages. In the first place, it has been too often the case that persons receiving care at Government expense receive an inferior quality of care which has often been called charity care. By providing service cards to these people we avoid the necessity of identifying them as recipients of Government assistance at the time they need hospital care, and we provide that they receive the same high quality of care as is today available to persons who purchase prepayment protection.

The second advantage is that an individual may apply for prepayment protection for himself and his dependents at any time whether or not hospital and medical care is needed at the time. The determination of need is made easier and does not complicate an emergency situation. There is criticism of the "means test" because of the embarrassment and delay to an individual at the time he is ill.

The third advantage is that persons of limited income are encouraged to pay part of the cost of their hospital and medical care. Medical protection would be assured, however, through the State health insurance agency while the individual contributed to his protection within his own financial limits. It is important that we maintain this sense of individual responsibility. The independence of our people has been America's strength and this is one way to maintain and encourage that independence.

Another basic purpose of the bill is to stimulate and encourage every self-supporting citizen to protect himself and his family against the cost of hospital and medical care by voluntary enrollment in prepayment plans.

The most costly illness the average individual is likely to encounter is that requiring hospital care. The cost of hospital or medical care under existing prepayment plans runs about $5 a month for the worker and his family. The hidden costs of a Government program would in the end be a greater burden upon the average individual. We can only imagine the infinite and vexing details of control that would have to be established for operation of a cast compulsory system affecting the lives and health of all the American people.

About a third of the American people now have some form of health protection through voluntary health insurance plans. A recent survey shows that an estimated 52,500,000 people are protected by voluntary hospital coverage; more than 26,000,000 have voluntary surgical expense coverage, and nearly 9,000,000 have medical expense coverage. More than 31,000,000 of the Nation's 58,000,000 employed civilians are insured under some form of voluntary protection against loss of income due to sickness or accident.

Now, Mr. Chairman, these plans have been built up under which a third of the people have some form of coverage and there has not been, so far as I have been able to observe, any great campaign of any kind to build them up. I never hear anything about these plans on the radio, I do not see anything about them in the newspapers, there has not been any great effort to build up these plans.

Senator Humphrey. In fact, the American Medical Association fought them for a long time.

Senator Hill. I think the record will sustain that fact. There has been no effort to build up these plans. These plans can be built up.

I can picture the acting chairman of this subcommittee, with all his power of eloquence and persuasion, addressing the people of the communities of Minnesota today challenging them, stimulating them, encouraging them to come in and build up this voluntary plan.

Senator HUMPHREY. I may help you on it.

Senator HILL. And that is exactly what I want to see done. I want to see the American people do this job.

Let me say this, speaking of the people who join these plans: The fact that there has been very little or no encouragement, and certainly no campaigns on behalf of these plans, if there is a place in our American way of life for the voluntary system, here is a voluntary program that cannot be ignored.

With universal participation voluntary health plans can provide more comprehensive protection than they do now, that is self-evident. The more members they have, the more members are taken in, the more extensive can be the protection they give. The bill gives assistance to the States to survey the extent of enrollment and to develop methods of broadening protection and increasing the number of persons enrolled. The bill provides for pay-roll deduction of subscription charges for Federal employees who request it, and encourages similar voluntary deduction for State and local Government employees.

The greatest impetus, I think the life-insurance companies will tell us, that was ever given the life insurance in this country was when the United States Government extended war risk insurance during the World War. By that very act of the Government the people became insurance conscious and thousands of people bought life insurance who never bought it before. Whenever you provide for membership by your Federal employees and your State and city and county employees, you have given a tremendous impetus, you have given a great impact to this thing of voluntary prepaid insurance.

Senator HUMPHREY. The Social Security Act had that effect, too, did it not?

Senator HILL. Of course it did. When persons enrolled in prepayment plans become unemployed, subscription charges will be paid during the period of unemployment compensation.

In other words, when they are unemployed, these subscription charges will be carried for them just as though they were on some pay roll.

In its broadest effect the bill will stimulate the coordination and full use of the Nation's health resources. The bill does this by assisting the States to survey their needs and to integrate the use of their hospitals and medical facilities in order to provide the greatest possible service for the greatest number of people.

In this the voluntary health insurance bill follows the tested pattern of the Hospital and Health Center Construction Act. Before ground was broken or foundations laid for a single hospital, the first year under that act was spent taking inventory of hospital and health center needs in each State. Once the facts were in hand, the States were able to move promptly with a construction program suited to their particular needs.

The proposed surveys under the voluntary health insurance bill will, I am sure, reveal different needs for different areas. Some areas may find that the network of hospitals, health centers, diagnostic clinics, and the supply of doctors and nurses and skilled technicians can provide a well-rounded medical service. Other areas may need additional services or facilities in order to provide proper care. Cooperative use of certain facilities may be desirable for some areas. All of these matters can best be determined by the people right on the scene.

The bill provides that the Federal Government pay half of the cost of the following types of surveys by the States and the local communities:

Surveys of existing diagnostic facilities. Proper diagnosis is a necessary element of medical care and the growth and development of diagnostic clinics will be encouraged, especially in rural areas, so that such services will be available to everyone.

Surveys of existing facilities and services and financing for mental illness, tuberculosis, and chronic diseases. The surveys will provide the basis for programs to increase and improve these facilities, at present considered primarily a State responsibility.

Surveys of areas which at present do not have adequate medical care because of economic inability to support a medical practice. We know that many areas, especially rural sections, have not been able to attract the doctors they need and this is a matter of deep concern to all of us.

When the States have determined their needs, the States and the Federal Government then can and must take definite, intelligent action. From our experience with the Hospital and Health Center Construction Act we know that the surveys have led to specific programs to meet the deficiencies revealed.

It is the responsibility of this committe, as I said in the beginning, to submit legislation upon which the Senate and the Congress can act. The health needs of our people demand action.

S. 1456 is a bill that can be passed, and passed now.

The reaction to S. 1456 shows the people are ready for this program. It has general support and it has approval from the medical and hospital professions—whose aid and cooperation are essential to the success of any broad program of hospital and medical care.

The voluntary health insurance bill builds upon our traditional medical practices and makes use of our free American medical institutions.

Gentlemen, there can be no doubt about the fact that under these practices and under our free American medical institutions, our people have enjoyed the highest quality of medical care of, certainly, any comparable nation in the whole world. The bill enlists the voluntary prepayment health insurance plans which now serve a third of our people.

The program under the bill can be put into operation immediately—put in operation now—to benefit those most in need of hospital and medical care. We have the doctors, nurses, and hospital facilities to proceed with the program. At the same time, the bill recognizes the practical limits to the medical care which can be immediately provided and does not precipitate the Nation into a program of universal medical care definitely beyond the capacities of our present health resources.

The bill is flexible and fosters the growth of the national health program to meet new needs and new conditions. As present programs go forward and increase the number of doctors and nurses and provide additional hospitals and clinics, we can provide in an orderly manner for expansion of the services which will be made available under the bill.

I have faith in the American people—their wisdom, their self-reliance. I have faith in their ability to do for themselves. The more we challenge and encourage and stimulate the people—the more they will respond, the more they will do for themselves.

The Hospital Survey and Construction Act has been inspiring proof of the ability and the desire of the people to act for themselves. Among the 48 States, Mississippi, Alabama, and North Carolina have perhaps the finest programs for hospital construction. Yet these are among the lowest States in the income of their people.

Through the voluntary health insurance bill the Federal Government will give financial aid and encouragement, leadership, and wise guidance to the medical-care program. But we rely upon the initiative and ability and resourcefulness of the people by placing full control and administration of the programs in the hands of the States and the local communities. The details of the programs will flow from the needs, the customs, and the determinations of the people. Democratic government must be government "by the people" as well as government "for the people."

This Eighty-first Congress has the opportunity to stand with the great Congresses of American history.

With the Sixty-third Congress of Woodrow Wilson's first term, which enacted the income-tax law, the antitrust law, created the Federal Trade Commission and the Federal Reserve Board, and provided for popular election of United States Senators.

With the Seventy-third Congress of the historic Hundred Days in 1933, which with bipartisan support enacted the many great laws that lifted our Nation from depression.

And with the Seventy-seventh Congress, which with bipartison support responded to Pearl Harbor with the laws that mobilized our Nation for global war.

Senator TAFT. What is the matter with the Eightieth Congress?

Senator HILL. Well, since the Senator has asked the question, I would like to answer it off the record.

(Discussion off the record.)

Senator TAFT. The Seventy-ninth Congress passed the hospital bill.

Senator HILL. Yes; the Seventy-ninth was outstanding, and bid for a great place in history because of the passage of the Hospital Construction Act.

The health of the people is the greatest resource of any nation. We can render no greater service to the people of America, and to the people of the world who look to a strong America for leadership to peace, than to enact this legislation for the health, the strength, the self-reliance, and the happiness of our Nation.

Let the Senate Committee on Labor and Public Welfare—our committee—give leadership and bring forth the legislation to make this Congress the great health Congress.

Senator TAFT. Are there any questions? Senator Donnell?

Senator DONNELL. No questions.

Senator TAFT. I am afraid we will not be able to wait for Senator Humphrey. We appreciate your statement.

Senator HILL. Thank you, sir. Mr. Bugbee is here, and is there anything you want to add, Mr. Bugbee?

Senator TAFT. I understood Mr. Bugbee would return at 10 o'clock tomorrow morning.

Mr. BUGBEE. Senator, the American Hospital Association is appearing later in support of S. 1456, so I think I need not appear now.

Senator HILL. Unless there is some question, you will come back with them?

Mr. BUGBEE. Yes.

Senator TAFT. The committee will recess until 10 o'clock tomorrow morning.

(Whereupon, at 12:45 p. m., the subcommittee adjourned, to reconvene at 10 a. m. Wednesday, May 25, 1949.)

NATIONAL HEALTH PROGRAM OF 1949

WEDNESDAY, MAY 25, 1949

United States Senate,
Subcommittee on Health of the
Committee on Labor and Public Welfare,
Washington, D. C.

The subcommittee met, pursuant to adjournment, at 10:05 a. m., in the committee hearing room, Senator James E. Murray (chairman) presiding.

Present: Senators Murray, Taft, and Donnell.

Senator **Murray**. The hearing will come to order, please. The first witness scheduled for this morning was Senator Lodge, but he will not be here this morning and will probably take the stand this afternoon.

Let the record show that due to the death of Secretary Forrestal, whose funeral is being held this morning, several members of the subcommittee are unable to attend. They will receive, and, I know, will study with care the transcript of this hearing.

The next witness to be heard is Prof. Seymour E. Harris, of Harvard University.

STATEMENT OF SEYMOUR E. HARRIS, PROFESSOR OF ECONOMICS, HARVARD UNIVERSITY, ON BEHALF OF AMERICANS FOR DEMOCRATIC ACTION

Mr. **Harris**. Mr. Chairman and members of the subcommittee, my name is Seymour E. Harris and I am appearing this morning on behalf of Americans for Democratic Action, an organization of progressives dedicated to the achievement of freedom and economic security through education and democratic political action.

I have been on the faculties of Princeton and Harvard Universities since 1920 and am now professor of economics at Harvard. I am the author of 21 books, the latest, Saving American Capitalism. Related to the problems under discussion, I have written a book on the Economics of Social Security (1941—out of print); How Shall We Pay for Education? (1948); the Market for College Graduates (in press); and, in preparation, the Economics of Medical Care. These are all relevant to the problem. For many years I have been responsible for the teaching of social security at Harvard. I am the editor of the Review of Economics and Statistics, and in the years 1945–48 was a member of the executive committee of the American Economic Association. I was in charge of the ADA Domestic Platform at the National ADA Convention of 1949.

It is not my intention to deal with all aspects of medical economics. I propose to deal with those aspects on which, by virtue of interest and training I hope to throw some light. In particular, I shall discuss the reasons for increased interest in national health insurance, the costs, the relevance of restrictionism and pricing, and the capacity of the country inclusive of Government to bear the burden; and I shall comment briefly on some aspects of the pending bills.

I shall not deal with significant aspects of the problem on which I am not particularly qualified to speak, e. g., the effect of the program on incentives, on regimentation, on the relations of doctors and patients. Here is an aside, however. For 30 years as a teacher, I have been subject to a kind of regimentation, to which doctors are now being asked to submit. For in education, there is Government and university responsibility for pricing. It seems to me that the system has worked well, and even better than if our rewards were determined primarily by student interest and choice and purely market considerations.

The objectives of economic policies are to stabilize, to raise the standard of living, and achieve greater equality. It is in terms of these objectives that I discuss the relevant problems of health insurance.

I. THE PROBLEM

In recent years, the pressure for health insurance has greatly increased. There are various explanations. First, this is an age when the people look increasingly to the Government for security. Protection against illness is one manifestation of the desire for security. Second, the public is becoming increasingly aware of the application of the insurance principle; the costs of serious illness are reduced for the population as a whole if they can be apportioned over the whole population. ("An unlucky sixth of our people * * * pays in 1 year half the total sickness bills paid by everybody.") In the thirties, one expert observed that 1 in 15 requires hospital care in any 1 year; and these expenditures account for one-half of all medical expenditures.

Indeed, voluntary insurance makes an important contribution. Mr. Ewing in his the Nation's Health (pp. 80–88) evaluates the contribution of voluntary insurance. According to this report to the President, 25,000,000, or 17 percent of the population have insurance for actual service in the hospital; but only 3 percent, or 3,500,000 have comprehensive insurance. Again, according to the Nation's Health, the costs of a comprehensive-insurance program would be 130 to 200 dollars per family per year. In June 1947 the minimum medical cost for a family of 4 in 34 cities was $132 in Mobile; the maximum, $222 in Los Angeles (5 to 7 percent of consumption outlays is the usual amount). Should we allow for the rise in prices since then, the minimum and maximum figures for a modest budget would be at least 140 and 240 dollars. (BLS: The City Worker's Family Budget, pp. 26–28.) Clearly, these expenditures would be an intolerable burden on the 12.8 percent of the Nation's families with gross cash income of $1,000 or less, a severe burden on the 15.4 percent with incomes of $1,000 to $2,000, and a serious burden for those (19.5

percent) with incomes of $2,000 to $3,000. Yet these are the families that especially need medical care.

This leads to the third point, namely, as the Committee on the Cost of Medical Care observed, the quest for medical security stems from the uneven distribution of medical care. The poor experience more illness and receive less care. To cite examples: One survey revealed 282 illnesses per 1,000 persons for those on relief, and 233 per 1,000 for those in comfortable circumstances. Another survey revealed that families on relief receiving $1,000 income or less received the aid of a physician for disabling illness 78 percent of the time; those with incomes of $5,000 or over, 89 percent. Those over the age of 65 experience four times as many days of disabling illness as the population as a whole; but spend only twice as much per capita on medical care. An early report (Public Health Reports, vol. 33, 1918, pp. 2044–45) shows that those with half-monthly incomes of $6 experienced 70 disabling days of sicknesses per 1,000 whereas those with $10 or over only 18.5.

Senator **Murray**. Would you tell us how much of the population is represented as coming within those income figures you specified?

Mr. **Harris**. Yes, sir; Senator Murray. I have those figures a little later, if you do not mind waiting for a moment. I have them by percentages later on.

Senator **Murray**. Very well.

Mr. **Harris**. Fourth, the aging of the population is a relevant consideration. In 1900 this country had but 3,000,000 or 4 percent of the population aged 65 and over; in 1948, 11,000,000 or 7 to 8 percent; by 1975, 18,000,000 or 11 percent. I might say that by the year 2,000 the figure will be 21,000,000 or 18 percent. Medical expenditures are a substantial part of all outlays by the old. As the population ages, the need for medical services will rise greatly; and particularly for those with limited resources. It should be noted, however, that insofar as more adequate provision is made for health, the burden of other programs on behalf of the old will be reduced.

May I say that on the average people 65 years of age and over spend about four times as many days in disabling illness as the rest of the population. Therefore, it is quite conceivable that within a reasonable period of time you will need 50 percent of the health facilities to take care of the old.

Fifth, the inadequacy of medical service has put pressure on the Government to do something. This inadequacy arises in part from the high level of employment in recent years, in part from the diversions of manpower to the military, in part from the improved standard of living which is reflected in a desire for more and better medical standards, in part from the failure of medical facilities to expand adequately, and part from the uneconomical organization of medicine.

Sixth, the development of programs abroad, the British program, the beginning of a Canadian program, the publicity given to the medical deficiencies of draftees—all of these have aroused public interest.

Seventh, the new economics of the last 20 years has gradually percolated to those who mold policy. This theory puts emphasis on the importance of finding a "corrective" for the results of man's high productivity. More consumption or (and) more leisure are the manner of absorbing the gains of progress. In the last 150 years, we have raised our standard of living by 8 to 10 times; and cut the hours of work from 60 to 70 to 40. More and more as we have learned to produce farm and factory products with less and less labor, we have turned to the tertiary industries (distribution, transportation, education, medicine, etc.) as the outlets for our released energies. Unless we find employment for our released workers through increased expenditures for services, the country will have to acquiesce to large amounts of unemployment (or corresponding rise in leisure), or to spending largely for war. Rising expenditures for recreation, religion, education, health, and so forth, are a happy way out.

In short, many reasons can be adduced for the increased interest in health insurance. The program, I would emphasize, is one for achieving a better distribution of expenditures for medicine and an increased outlay. The country may not be able to afford to allow private choice to determine total outlays on medicine any more than it does in education. Surely consumers need some guidance when they spend $7,400,000,000 for medical care and health expenses, as compared to $2,750,000,000 for tobacco, $2,300,000,000 for personal care—largely beauty care—$15,500,000,000 for transportation, $9,400,000,000 for recreation.

II. COSTS OF MEDICAL CARE

1. Importance

Even at the bottom of the depression, the Committee on the Cost of Medical Care for the American People estimated that outlays of 100 to 200 dollars would be required for a family of five. The average family of five earning $1,500 could not afford an outlay of 7 to 13 percent of their income even though the country could afford it. Hospitalized illness then cost $150 per case on the average, and was a serious burden on the less than 10 percent of the middle- and low-income group thus affected in any one year. (Final Report, pp. 35, 132.)

> The prevailing methods of purchasing medical care have unsatisfactory consequences. They lead to unwise and undirected expenditures, to unequal and unpredictable financial burdens for the individual and the family, to neglect of health and of illness, to inadequate expenditures for medical care, and often to inequitable renumeration of practitioners. There needs to be some plan whereby the unequal and sometimes crushing burden of medical expenses can be distributed. (Final Report, p. 34.)

In 1947, private disbursements on medical care and death expenses were $7,400,000,000 or 3½ percent of the national income, and 4½ percent of all consumption expenditures. (Survey of Current Business, July 1947 and July 1948.) Outlays of Government were $2,000,000,000 additional. Government outlays were largely for hospitals ($1,400,000,000), community health protection ($360,000,000), medical care of the needy, noninstitutional, $150,000,000,000). (The Nation's Health, p. 28.)

The following observations should be made about the costs of medical care:

2. Disappointing outlays for medical care

In 1933, the public disbursed $2,400,000,000 or 6 percent of the national income on medical care; in 1947, the respective expenditures were $7,400,000,000 or more than 3 percent. Surely if the country could pay 6 percent of its income for medical expenses in 1933 (4½ percent in 1929), the country can afford more than 3 percent in 1947–48. In an advancing society, the country is supposed to spend an increasing percentage of its income on services. That we have failed to follow this pattern in medicine is explicable in part by the unavailability of facilities, in part by the unequal distribution of services, in part by the methods of finance. What is required is more help for the poor and an insurance program which covers everybody.

3. Gross and net costs

Let us assume that the costs of medicine, inclusive of $2,000,000,000 additional Government outlays other than for insurance (as suggested by the Nation's Health), should eventually rise from the present level of $9,500,000,000 to $14,000,000,000. Then the total gross cost would be 5 percent of the likely national income of (say) 1960, or a smaller percentage than in 1933 and roughly equal to that of 1929 when money income was little more than one-third as high and real income about 60 percent as high as in 1948.

But there are important offsets to any rise in the gross outlay for medical care. According to the Nation's Health (pp. 27–28), the annual losses due to incapacitation ($11,000,000,000), to partial disability ($11,000,000,000), short-term sickness ($4,500,000,000), premature death ($11,000,000,000) are in all $38,000,000,000 a year. These are of course highly conjectural figures; and have been citicized by medical men as being too high. But whether the correct figure is $38,000,000,000 or only one-quarter of $38,000,000,000, the correct figure is a significant item and should be considered in assessing the costs of an expanded program. It would not be an exaggeration to say, for example, that the additional expenditures suggested here by 1960 (e. g., 4–5 billions annually) could easily be met by savings on illness and premature deaths. This is a modest estimate and more than allows for the possibility that there is much malingering and that many of those now unavailable as result of illness, and so forth, might not be absorbed in the labor market.

A second offset is the gain to be expected from finding an outlet for energies released from the advance of science. We must spend more for services. Any method of finance which provides larger outlays for services and particularly such worth-while outlays as health, deserves strong support. Increased expenditures for health will then to some extent come from resources which would otherwise be unemployed. The need for additional expenditures for medicine is so great that even if the Government accepted the recommendations of the Nation's Health (pp. 28, 30) and increased expenditures for community health protection (prevention) from $316,000,000 in 1947 to 1,250,000,000 in 1960 and thus greatly improved the Nation's health, there would still be scope for additional outlays. But we should observe that increased expenditures would in turn reduce the need for treatment.

III. THE RELEVANCE OF RESTRICTIONISM

1. The need of more services

Once the Government subsidizes low-income groups adequately and through insurance assures larger disbursements for medical care, then the pressure on medical facilities will rise. This will result in part because much-needed medical care will now be demanded; and in part because once the expenses are pooled, there is a tendency to be wasteful of use of medical facilities. I could say a word about the British situation, but I would rather go on and not say anything now about that. In my opinion the first factor is much more important than the second.

I shall say something presently about the need of additional services, and in this statement I emphasize the need of additional outlays on medicine. But we must italicize the following:

(*a*) The response of trained personnel is a slow process. It has been altogether too slow in the professional medical field. Vigorous legislation is required to increase the personnel. By the way, the response of all engaged in medical and health services (1929–47) has been much more satisfactory than that of doctors. The total number engaged in industry rose by 27 percent; the numbers engaged in medical and health services by 36 percent; the rise of physicians and surgeons about 10 percent. I might say that from 1933 to 1947 the last figure was 5 percent.

(*b*) It follows that any rise of outlays in the short run will merely increase the rewards of those already entrenched in the industry or profession (as has largely happened since 1932), unless vigorous measures are taken to improve the organization and make more effective use of trained personnel and physical facilities. For this reason, it would be wise to expand outlays slowly—perhaps 1 to 2 billion dollars annually in the first 5 years; and then 2 to 4 billion dollars in the next 5 years. Beyond 5 to 10 years, we may expect large expansion of facilities and the possibility of much larger outlays.

(*c*) Much better use could be made of existing personnel and facilities thus assuring a rise in services corresponding to the suggested increase in outlays. Furthermore, the training of subsidiary personnel could be accelerated much more quickly and with more immediate results than that of the doctor or dentist. The country would profit from better organization of medicine inclusive of up-grading of the work of technicians, thus conserving the doctors' or dentists' time for the work requiring high skills. Why should my dentist clean my teeth, or my doctor get information from me which a good stenographer could obtain?

(*d*) The AMA figures on the rise in the cost of medical services quoted elsewhere in this statement are of some significance. The increase in unit costs of services of doctors of all kinds is 36 percent; but since the average doctor receives at least 100 percent more than in 1935–39, this suggests that he does on the average 50 percent more business.

Senator TAFT. Where does that figure come from?

Mr. HARRIS. Senator Taft, that figure comes from the Survey of Current Business, the total expenditures on consumption, which are itemized by different kinds of medical expenditures. In July 1948, these figures were itemized and the increase is more than 100 percent.

Senator TAFT. You mean paid to each doctor, to all doctors?

Mr. HARRIS. Each doctor. We have a total figure and also the number of doctors.

Senator TAFT. That is taking the total sum and dividing it by the number of doctors?

Mr. HARRIS. That is right, yes, sir. I might also suggest that he has 50 percent more callers, more operations, and so forth; but is harassed sufficiently so that the quality per unit is less satisfactory than before the war. Then, his charge is up by much more than 36 percent for identical service. Incidentally, the increase in hospital charges by 112 percent also points to an increase in charges by doctors of more than 36 percent.

I have a few figures which I put together since having this paper mimeographed. I have taken figures from 1900 to 1960. The population from 1900 to 1960 will have increased by two-thirds, the national income by 10 times, the real income by 5 times, the number of old by 4 times, the number of doctors by one-half.

Now, I would like to say that it seems to me that this country, in view of these figures and in view of the possibility of getting a better distribution of medical facilities, this country could easily afford and make good use of 400,000 doctors as against an estimated supply in 1960 of 210,000 or 220,000.

I would also like to point out that the expansion of medical facilities has been disappointing.

2. Past growth disappointing

It is, however, important to provide additional doctors, dentists, and facilities. In the past the expansion of medical facilities has been disappointing. For about 40 years the enrollment (around 20,000) and the output of graduates (about 5,000) in medical schools has remained roughly unchanged. Yet in this period, the population has increased by more than two-thirds, the money national income by 10 times, and the national income in stable dollars by about 5 times. Indeed, the stabilization of enrollment has partly been a process of raising standards; but there are also signs of restrictionism, of protecting the interests of the present members of the "trade-union."

The response of doctors has been disappointing in relation to other professions also. In 1870, about 1 in every 6 college graduates became a physician; in 1946, the proportion was 1 to 186. From 1870 to 1940, the percentage of physicians to population remained unchanged at 0.13 percent; of dentists the rise was from 0.02 to 0.06; and the proportion of engineers doubled from 1910 to 1940, whilst that of physicians declined from 0.16 to 0.13. From 1910 to 1940 the number of physicians rose by but 13 percent although population increased by 43 percent and real income per capita by 21 percent. From 1933 to 1946 medical expenditures rose by 200 percent; but the accompanying expansion of practitioners was less than 5 percent.

It is no wonder that medical economics can report gross incomes of $17,000 for physicians in a recent year (net incomes are substantially less); or that the National Bureau of Economic Research finds that independent medical practitioners earn from 80 to 180 percent in excess of what can be explained by additional costs of training. In the years 1933 to 1946, the rise of outlays per physician was more than 150 percent as compared with an increase in the cost of living of but 70 percent. Teachers have encountered great difficulties in obtaining a rise in their incomes equal to that in prices. College professors average a rise since 1939 of about 25 to 30 percent as compared with one of about 100 percent for physicians. A failure to expand medical training with the growth of population and income has resulted in disproportionate gains for those fortunate enough to obtain licenses.

That means on the average the average doctor has improved his real standard of living from 1939 by something on the order of 25 or 30 percent, while the average professor has reduced his by 25 or 30 percent.

Senator **Murray**. How do you explain the failure to expand training of doctors during this period?

Mr. **Harris**. Senator Murray, it is difficult to explain. Of course, there has been a very serious shortage of medical schools, and I think in the past there was a great dependence on philanthropic resources.

Senator **Murray**. Has there been any effort on the part of the American Medical Association or other organizations to try to bring about an expansion of educational institutions for medical training?

Mr. **Harris**. I would say it has been disappointing to me. The American Medical Association is a well-organized group, and they certainly make their influence felt in these matters. Perhaps I am somewhat ignorant of the situation, but I am unaware of any really significant effort made by the American Medical Association to get more medical schools and the corresponding amount of hospital training facilities for those medical schools.

Senator **Murray**. I remember what a great scarcity of doctors there was in the country when we were preparing to enter into the late war. Hearings were held here, and there was testimony to the effect that it was going to be a difficult thing to get the doctors necessary to take part in the war; and yet nothing has been done since that time to try to bring about an expansion of training for the medical profession.

Mr. **Harris**. I agree with that absolutely.

Senator **Taft**. That is largely due to the great cost of teaching doctors, it is not?

Mr. **Harris**. That is true.

Senator **Taft**. Is not that the primary reason?

Mr. **Harris**. It costs $2,500, it is said by medical schools, to turn out a doctor, $2,500 per year to train them. The student generally pays about $500 on the average. That means you require a subsidy of $2,000.

That is not very serious in a way because the medical schools at the present time, as I understand it, pay out about $50,000,000 a year for training, so that if you could double that amount, you could increase the total output per year by 5,000. I think in the long run that would give you an adequate supply of doctors.

Senator **Taft**. Also you would increase the equipment and the buildings, et cetera, and possibly hospitals to go with the new medical schools?

Mr. **Harris**. That is right, Senator Taft, and I gather some provision in your own bill would help achieve that.

Senator **Taft**. I am on the board of Yale University, and the medical school is, of course, a constant drag on the general funds of the university. We have no endowment anything like sufficient to make this up. I think our tuition is higher than $500. I think it is $700, but that still makes around $1,800 per year per student, and there is no great inducement to increase the facilities to get more students to lose more money.

Mr. **Harris**. That is quite true, and the philanthropic money is not coming in the way it used to.

Senator MURRAY. Yet the polls show there is a greater and greater desire on the part of young people to enter the profession.

Mr. HARRIS. Oh, yes. As a matter of fact, I understand from some surveys made in New York State by the State commissioner of education that there are about three times as many people willing and able to go to medical schools and college as can actually be admitted.

Senator MURRAY. This is a serious defect in our economic system, because as you point out, our economy is developing to that state where more and more people have to go into services and we are failing to provide opportunities along that line.

Mr. HARRIS. Yes, sir.

Senator MURRAY. And this profession is the profession that should be expanded more than any other.

Mr. HARRIS. Yes, sir; I agree with that.

Senator DONNELL. May I ask a question?

Senator MURRAY. Yes.

Senator DONNELL. Professor, on page 7 of your statement you say:

> It is no wonder that Medical Economics can report gross incomes of $17,000 for physicians in a recent year (net incomes are substantially less).

Do you mean that is the reported average gross income of all doctors in the United States, $17,000 per year?

Mr. HARRIS. The arithmetic mean.

Senator DONNELL. The arithmetic mean?

Mr. HARRIS. Yes, sir.

Senator DONNELL. Does that mean if you take all the doctors in the United States, every one of them, that the average gross income of all those is $17,000?

Mr. HARRIS. Yes, sir.

Senator DONNELL. What is the date of the issue of Medical Economics?

Mr. HARRIS. I can send it to you.

Senator DONNELL. Do you remember how many of these doctors were over $17,000 and how many were under?

Mr. HARRIS. There was one who earned $186,000. That was the peak pay.

Senator DONNELL. So those with the highest income entered into the computation?

Mr. HARRIS. Yes, sir.

Senator DONNELL. You do not mean to say that in the average community, we will say a town of 20,000, such as in my home State, for instance, that the doctors there on the average are making $17,000 a year gross?

Mr. HARRIS. I would say probably the doctors in the rural and small towns are making substantially less than $17,000.

Senator MURRAY. In many places they do not make more than two or three thousand; is that right?

Mr. HARRIS. I am sure of that, and it means in the big cities they make an awful lot more frequently.

Senator DONNELL. You will give us the date of this issue?

Mr. HARRIS. Yes, sir; I will make a note of that.

Senator DONNELL. If you have a copy handy that you could send to us for insertion in the record, I am sure with the chairman's permission, we would be very happy to have it.

Mr. HARRIS. Yes, sir.

Senator TAFT. Have you the figures on the relative number of doctors in the United States per person as compared to other countries?

Mr. HARRIS. I have had those. On the whole, the United States has the largest number in relation to population of any important country. I think we average about 1 to 750 in the population. In the Scandinavian countries it is 1 to 2,000. In China it is much less.

Senator TAFT. If there is a lack of doctors in the United States then there is a much worse lack of doctors in every other country in the world; is that correct?

Mr. HARRIS. Yes, sir; I would agree.

Senator DONNELL. You do not have with you this morning a copy of that issue of Medical Economics?

Mr. HARRIS. I am sorry, I do not, but I will get you a copy or give you the reference.

Senator DONNELL. Thank you.

Mr. HARRIS. This is a rather important issue, and I developed this very fully in a book I wrote.

3. The problem of pricing

My object is not to belittle the important service contributed by the medical profession. They have worked hard, put in many long hours and carried a tremendous responsibility in the last 15 years. According to figures released by the A. M. A. (Bull. 67, p. 13), the charge for physicians' services (general, surgeon, specialist) was up by but 36 percent in 1948 as compared with a rise in the consumers' price index of 71 percent. This indeed shows restraint on the part of the medical profession. But undoubtedly physicians have had to reduce demand on their services by raising prices; and even these figures may understate the rise, for allowance must be made for increased collections. A disturbing element in the medical picture is the rise of hospital rates by 112 percent from 1935–39 to 1948. This is a rise beyond that of prices in general. It underlines a point that is important, namely that physicians and dentists account for but one-third of medical expenditures; and any reduction in costs and prices must extend to drugs (with the highest advertising costs in any industry), hospitals, and so forth.

The real issue is one of pricing and service. An improved method of financing will make it possible to employ more doctors and dentists. What is required is more business and lower fees per visit.

4. The market for doctors and the problem of outlets for the educated

At the present time the country has about 200,000 doctors. This country should be able to support 400,000 doctors at our income levels—in part through making more funds available and in part through a reduction of prices charged.

It is important that the country find an outlet for increased numbers of physicians, dentists, and other trained medical personnel for another reason. By 1968 this country will have from 10 to 15 million college graduates as compared with 3 million in 1940 and 4½ million in 1948. We are heading toward a college graduate population of 30,000,000, 25 percent of our adult population. An outlet must be found for these graduates commensurate with their abilities and training. Medicine offers one possible outlet. In 1940 medicine accounted for about 8 percent and in 1947–48, 7 percent of the living college graduates. Should the proportion of doctors and dentists to living college graduates remain unchanged from 1940 to 1968, there would be from 1.2 to 1.6 million doctors, dentists, and so forth. Obviously, the country could not support medical men and women in such large numbers. But it would do well to support as many as it can afford.

Senator TAFT. That suggests that the whole thesis is wrong. After all, we are educating more people in college on the theory that all our businessmen and everybody else ought to have a college education. There was a time when people went to college only if they were going into a profession, but the purpose of increasing college graduates is to have a college education for everybody, whether they are in the professions or not; so I do not see the relation between the number of college graduates and the number of doctors.

Mr. HARRIS. I think this is a very real issue, very relevant. May I elaborate?

Senator TAFT. Surely.

Mr. HARRIS. You have a problem now which, of course, has been a great problem in Europe, the problem of the proletariat of the Ph. D. You turn out an intellectual who expects a certain kind of job. As a matter of fact, you have available in this country roughly five to six million high-class jobs which a college graduate would like to have. Half of those are in the professions and half are in business.

When you are confronted with 15 million college graduates seeking 6 million jobs they would like to have and who will be frustrated if they do not get these 6 million jobs, then you are encountering a bad situation.

Senator TAFT. You would rather not have so many people going to college. I thought the theory was that everybody should go to college, every mechanic and everybody else should have a college education. I do not see why they should be frustrated if they cannot get a certain kind of job.

Mr. HARRIS. I have been teaching for 30 years, and my impression is from talking to these students that they go to college because they want a high-class job.

Senator TAFT. Everybody in the country cannot have a high-class job. You have got to have 60,000,000 people working, and they have to cover the whole field of all the jobs you have.

Mr. HARRIS. Here is one solution. It is to find as many high-class jobs as you can. Do not let the American Medical Association or anybody else restrict the number of jobs.

Senator TAFT. I agree as to the lack of restriction. Everybody who wants to go into it should go into it if he can qualify. I agree on that.

Mr. HARRIS. The second solution is: Do not go to college just to get jobs. It is the job of the Government and the universities to tell students that this is the market situation and your chances are thus and so. That is, to get these jobs.

Senator MURRAY. I often run into a taxi driver who tells me he is a graduate of some university with a degree.

Senator TAFT. Do you find him frustrated?

Senator MURRAY. He is apparently satisfied with the situation.

Mr. HARRIS. Senator Taft, you know there was a study made of the Members of the Reichstag belonging to the Nazi Party and this study showed quite conclusively that there was a disproportionate number of well-educated members and a disproportionate number of intellectuals who had failed to receive the kind of job they would have liked to have had.

Senator MURRAY. I remember in the depression years a situation in Montana where the professional men were having a difficult time making a living, and they were complaining about it, and one of the miners out there said to this doctor or this lawyer, "Why don't you go and get a job?" He said, "What can I do? I haven't got any education."

Mr. HARRIS. Well, Senator Taft, you know at Yale Dean Clark suggested restrictionist measures in the depression with regard to the law profession.

Senator TAFT. There are times when the average lawyer got a very low income indeed.

Mr. HARRIS. That is true.

Even today the applications accepted in New York Medical College are but one-third of the total applying (State of New York: Inequality of Opportunity in Higher Education, p. 47). We could easily support 2,000,000 in the medical and health area as compared with 1,000,000 today.

5. The prospects for more doctors

Both in terms of the desire of potential doctors to enter the medical profession and in terms of needs, there is a great unfilled demand for medical services. Thus in 1939–40, 38.5 percent of the males received medical care when ill; for disabling illness which confined to bed the proportion was only 70.3 percent (F. S. A.: Medical Care and Costs, p. 100).

Under health insurance, it will be possible to obtain increased services by improved organization. Nevertheless, at the outset, it will be necessary to limit the services available. In the longer run, there will be an increase in the number of hospitals, medical students, and doctors. Even if within 5 to 10 years we could raise the annual output of physicians from 5,000 to 10,000, it would still require at least a generation before we had increased the number of physicians to 400,000. According to the Nation's Health, the country will have to take vigorous measures to raise the total of physicians by 1960 to 227,000—12,000 in excess of the numbers expected—and dentists to 95,000—5,000 in excess of expected numbers. It is clear that it will be at least 40 years before we could have 400,000 physicians. Even the Ewing program will require a rise from $15,000,000 for manpower training in 1947 to $127,000,000 in 1960 (the Nation's Health, pp. 30, 38–46).

IV. CAN WE AFFORD IT?

A national health insurance program involves for the most part a conversion of payments for medical services from private to public sources. In this sense they are not additional. They will involve, of course, a redistribution of services. To some extent, the administration program also calls for additional outlay. That is besides the insurance program.

1. Who pays?

The financing of the program is likely to be largely by pay-roll taxes, and secondarily from general taxes, although I gather the administration suggests 4.2 billion dollars to be pay-roll taxes and one-third additional through general taxes. Insofar as the financing is by pay-roll taxes, the costs will be largely borne by the workers. It is the accepted theory of classical economics that a pay-roll tax, whether paid by workers or employers, is ultimately borne by the worker. His pay is determined by what he produces: he now receives part in wages and part in social security benefits. (For a technical analysis, see Economics of Social Security, pt. III.) The workers will also bear some part of the general tax burden. Hence the financial burden on the general taxpayer should not rise greatly. Incidentally, the British Chancellor of the Exchequer, Sir Stafford Cripps, in introducing his last budget speech said that the taxpayer would have to pay for the additional costs of the social security program, and that a large part of the burden now rests on the recipients of the benefits (Hansards, vol. 96, p. 2091).

2. Relation to the budget

Much is made of the fact that with a $40 billion budget, with commitments to veterans, public debt payments, international aid, and the military of 30 billion dollars, the country cannot afford to expand its social services, however meritorious the programs are.

But this is not a decisive argument. First, because it might be possible to finance worth-while new expenditures by eliminating some present wasteful Government expenditures. The President estimated total expenditures for social welfare, health, education, and housing for fiscal year 1950 at but 3.2 billion dollars; and the additions for 1950 under proposed legislation at only 600 million dollars, out of 6.2 billion dollars proposed under new legislation (Budget, M13, M69, 70).

Second, the possibility of depression conditions underlines the need for this program. The current situation, and notably the decline in output, the rise of unemployment, the reduction of investment inclusive of inventories (little more than 1,000,000 auto batteries were released by manufacturers in 2 months, February, March 1949, for 40,000,000 cars), the failure of recovery in April, all suggest a recession in 1949—and one that might snowball unless strong measures are taken. The correct policy seems to me to be a reduction in excise taxes and a rise in expenditures. It is indeed true, as Senator Douglas says, we must not deploy our reserves too early; but also we must not allow a break-through which might cause substantial damage. The danger of a small depression is that it easily snowballs into a larger one.

I mention this battery example just as an illustration of what businessmen are doing. It indicates a tendency to disinvest.

Third, it is well to emphasize that these are transfer expenditures. What one pays out another (generally the same person) receives. They largely mean using resources that would otherwise be used anyway. But to some extent they mean discouraging excessive savings and therefore stimulating total spending. When you are protected against the vicissitudes of illness, you save less.

Fourth, the charge on the national income is large but easily bearable. A tax bill of 40 billion dollars seems large; but only 20 billion dollars are direct taxes that are relevant for the net national income. In a period in which national income rose by 180 billion dollars, direct taxes rose by but 20 billion dollars and the debt charge by but 4½ billion dollars.

Senator MURRAY. What happens in that situation? Too large an amount of income being stored away?

Mr. HARRIS. You mean in case you do not provide for health insurance? I think there is a tendency for people to save too much. In other words, you are protected, if you agree to my general thesis that in a normal peacetime economy with the population not growing too rapidly, there is a danger of oversaving. Then the difficulty is people are encouraged to save by virtue of the fact that they are afraid of illness.

If their illness is taken care of by the Government, that will to some extent discourage excessive saving.

Senator DONNELL. You think it is dangerous to have saving beyond a certain amount?

Mr. HARRIS. Yes, sir; it depends on the conditions. In the nineteenth century we needed saving badly. The British need it now. Our economy does not.

We invested in business equipment and plant in the 3 years, 1946, 1947, and 1948, at such a rate that in 10 years we could have had a completely new plant for business.

Now, you cannot go on investing at the rate which was in effect in 1946, 1947, and 1948, and that simply means you cannot go on saving at that rate.

Senator DONNELL. Do you not think it is a pretty good general policy for the individual to lay aside quite a substantial amount for a rainy day in the future?

Mr. HARRIS. That is one of the great difficulties, and it is unfortunate. There is a conflict, in my opinion, between the interest of the individual—and I myself act in an antisocial way because I do save, but at the same time I do have bad dreams about the fact that I save because in saving I do something that is antisocial in the sense that we have too much savings.

Senator DONNELL. You think that although you save and try to lay up something for yourself for a rainy day, that you are committing a social inequity and a social injustice by saving for yourself and your family?

Mr. HARRIS. My view is it is antisocial for me to save too much.

Senator DONNELL. What is too much? I do not mean personally, but how would you decide how much is too much for a person to save?

Mr. HARRIS. This is all a very rough estimate, but I will put it this way: In 1948 this country was investing 40 billion dollars. I say that is too much because we cannot maintain it, and it is bound to bring a depression.

I would say if the country were saving 20 billion dollars in all and I were doing my share, I would not be saving too much. If you make 20 billion dollars available for plant, you are reconciling your behavior with society. But if your behavior is such as to make the figure 40 billion dollars, you are acting in an antisocial way.

Senator DONNELL. You should spend your income liberally?

Mr. HARRIS. Yes, sir.

Senator MURRAY. What you are saying applies more to business and industry than to individuals, does it not? As I understand it, during the last 10 years the corporations of this country have been earning so much that they have been able to set aside for their treasuries such enormous amounts that they do not have to go any more to the banks to borrow money to expand plant or enter into new fields.

Mr. Harris. Yes, sir.

Senator Murray. You think that tremendous saving and setting aside in industry is not a good thing?

Mr. Harris. Well, you know, Senator Murray, the arguments, and I did testify at the profit hearings, and an argument was used a good deal that business needed profits and the only way to get capital was to get it through profits. I argued that that is not a valid argument, although it is perfectly true you have to have large profits to have adequate savings, but we have come to the point where profits were too high and savings were too high.

In other words, with business spending all that money in these 3 years, they are getting to the point where they would not find any outlets for their savings.

I do not know if I make myself clear.

Senator Murray. You may go ahead.

Senator Donnell. Mr. Chairman, I think I would like to examine the professor a little later on in regard to this question of savings.

Mr. Harris. It is a little shocking.

Senator Donnell. It is.

Senator Murray. You may proceed now, if you like.

Senator Donnell. I will proceed now, if I may.

Professor, it is certainly a decided departure from all of the traditional ideas, that saving may be excessive as applied to the individual.

I mean to say with the exception of a miserly saving in the case of a man who never spends anything and lives in grime and dirt and disease in order to save money, there may be an evil there, but I am talking about the normal saving that you as the head of a family would want to make for yourself and your children and your wife and to have something in your old age to provide against eventualities, I say it is a very striking change from the principles of 150 years or more in this country to advocate that people better not adopt that policy of saving to the extent previously considered. Do you agree with that?

Mr. Harris. I am afraid I do not. I agree it is shocking.

Senator Donnell. It is a shock?

Mr. Harris. Yes, sir; but I still maintain my position.

Senator Donnell. I do not want to interrupt you except to make this clear. What I was trying to get at is: You do agree that the doctrine you are advocating here this morning is a shocking doctrine as compared with the previous conception in our country? Do you agree with that?

Mr. Harris. I would not say it that way. It seems shocking when presented in that way, but one should not withhold a statement merely because it may shock people if the person makes it thinks it is correct.

Senator Donnell. Certainly, but it does seem shocking, do you agree?

Mr. Harris. It does seem shocking.

Senator Murray. To anyone who whould not understand the theory.

Mr. Harris. Yes. Of course, it is a theory, and I might say that even early in the nineteenth century Malthus presented a somewhat similar theme and John Stuart Mill did, too, talked about the time when you would have a stationary state, and he said in 1848 that the time would come when you would have a stationary state and people would save so much.

Senator DONNELL. Malthus was the man who laid down certain theses in regard to population?

Mr. HARRIS. Yes, sir. In its drain of resources, the Government still accounts for one-eighth of the total output just as it did in 1933. It is well to compare the 40 billion dollars of income in 1932 and the 225 billion dollars in 1948 and consider the important contributions of the rise of Government spending.

Fifth, from a long-run viewpoint, it is imperative to increase the outlays on medicine. This is an important outlet for spending; and unless means are found to cut savings and increase spending, there are serious dangers of deficiency of demand, wasted resources and unemployment.

Senator DONNELL. I would like to have noted that the professor says that unless means are found to cut savings and increase spending, there are serious dangers of deficiency of demand, wasted resources, and unemployment.

Mr. HARRIS. Yes, sir.

Senator MURRAY. We could save ourselves into a depression very easily?

Mr. HARRIS. Yes, sir.

Senator MURRAY. And that is beginning to appear at the present time?

Mr. HARRIS. Yes, sir.

Senator DONNELL. You think that generally speaking the people in this country are too saving at this time?

Mr. HARRIS. Yes, sir; I am inclined to think so.

Senator Donnell, may I say this:

We would have had a depression a long time ago had it not been for the war and the wartime expenditures. That is the spending that has kept us out of a depression.

Senator DONNELL. I note you follow by saying that the only other alternative is large outlays for war.

Mr. HARRIS. Yes, sir.

Senator DONNELL. You say that there are serious dangers of deficiency of demand, wasted resources, and unemployment unless means are found to cut savings and increase spending.

Mr. HARRIS. That is right.

Senator DONNELL. And that the only other alternative is large outlays for war?

Mr. HARRIS. Yes, sir.

Senator DONNELL. Very well.

Mr. HARRIS. That is one of the penalties you pay for being too rich, because as you become rich, you save. A man with a $10,000 income saves more than a man with $2,000 income. As I say, the only other alternative is large outlays for war. And should world war III come, we shall not be sorry for increased medical facilities.

Those who say we cannot afford these outlays should compare the British budget. Their taxes account for 40 percent of their income, ours but 25 percent; their defense expenditures 7½ percent of their income, ours 6½ percent; their social services require 3.4 billion dollars or 8½ percent of their income (5.4 billion dollars or 13½ percent inclusive of food subsidies) and ours only 7 billion dollars or 4 percent of our income. Yet the British per capita income is $800, ours $1,600. And despite these heavy charges, the British have made a truly remarkable recovery.

Senator DONNELL. Somewhat assisted by America in that recovery; is that right?

Mr. HARRIS. Yes, sir; but still they have done a remarkable job if you consider the fact that they are producing more than they did in 1939, having lost the equivalent of 2 years' income as a result of war damage, and have virtually wiped out their deficit in the balance of payments. I think they have done a wonderful job.

V. COMMENTS ON PROPOSED LEGISLATION

The Senate has under consideration three bills: (1) The national health and insurance bill (S. 1679; H. R. 4312, 4313) is a comprehensive health program. This is the administration bill. (2) The voluntary health bill (S. 1456) sponsored by Senator Hill and others. (3) The national health bill (S. 1581) sponsored by Senator Taft and, I believe, Senator Donnell, and others.

Senator DONNELL. Also Senator Smith.

Mr. HARRIS. Yes, I compare these bills below.

1. Comprehensiveness

The administration bill (S. 1679) is much to be preferred on these grounds; for it not only offers wide coverage, but it also deals adequately with additional training facilities, rise of personnel, hospitals, aid to rural areas, preventive measures, public health, research. The Taft bill also makes some provision for improving health services, liberalizing the Hospital Survey and Construction Act, and increasing manpower.

I read the Taft bill after I wrote this. I must say it does make important contributions, although my preference is for the administration bill.

2. Coverage and costs

The administration bill (S. 1679) provides coverage for about 85 percent of the population, inclusive of the employed, self-employed and their dependents, beneficiaries under old-age insurance and provides aid for others short of resources through governmental participation. The Taft bill proposes help for the indigent.

It is not clear how many would be covered under the Taft bill, but an ultimate appropriation of 300 million dollars is suggested. Inclusive of State participation, this might cover 10 to 12 millions. In 1947, there were 13 percent—17 millions—of the population with incomes less than $1,000, and 31 percent—44 millions—with incomes of less than $2,000. At the time the cost of a modest budget for a family of four was estimated at around $3,300. It would be no exaggeration to assume that the costs of the Taft program for subsidies to the poor alone would be 2 billion dollars. Of course, the appropriation is not anywhere near that large. (All those with incomes less than $2,000 might receive help.) Actually in 1939 the

A. M. A. estimated that families with incomes under $3,000 could not afford a serious illness. This is the equivalent of $5,000 today and, therefore, the A. M. A. estimate suggests help for 80 percent of all families.

The Hill program provides help for those who cannot afford to join voluntary agencies. Perhaps the costs would equal those of the Taft program. The administration program would, however, according to an estimate of the Social Security Board reconsidered by Soule, cost little more than 1 billion dollars over current outlays for the services offered under the administration bill. S. 1679 would have the advantage of making the resources available on an insurance principle to virtually the whole population. This would be especially important for the 80 percent of the families with incomes of less than $5,000.

3. Who should benefit?

The major issue between the administration bill, on the one hand, and the Taft and Hill bills, on the other, is that of coverage and the insurance versus the charity principle. It has been a cornerstone of social security in this country that the beneficiaries contribute and receive benefits as a right. It is their fund that finances the benefits. It has also been a fundamental principle that coverage should be as complete as is administratively possible. The administration is dealing with this problem in other parts of the social security program. The Taft and Hill bills mark an important departure from social security as an insurance program, to social security as a hand-out. Indeed, the Taft and Hill proposals would concentrate their help on those who need it most, the indigent. But in so doing they deprive the vast part of the population of the benefits of a national health insurance.

Senator MURRAY. If that system were to be expanded and put into effect, do you not think it would gradually result in the expansion of that into a total program for the whole country?

Mr. HARRIS. You mean the Taft bill?

Senator MURRAY. Yes, sir.

Mr. HARRIS. Yes, sir. I think the tendency would be to extend help much further than the appropriation suggested on the bill would make possible.

Senator MURRAY. Yes.

4. Control

Mr. HARRIS. These bills also raise some questions concerning control. The control should rest largely with the public, that is the consumers, not with the organized medical profession. No one has yet suggested that the teachers should control the educational system, and bankers are not supposed to control our monetary machine. Nor, for that matter, are the public utility people supposed to control their own rates. Indeed the medical profession should play an important part in all technical matters and even in general administration.

5. In general

Even the administration bill might be considered only a beginning. It will be a long time before the country has the medical personnel, hospitals, and other facilities that this country can afford. Total expenditures for medical care, both private and public, are today less than $10,000,000,000, or about 4 percent of the national income. We can certainly look forward, if we are spared a major war and experience good management, to a national income of $300,000,000,000 by 1965. (That is a rate of growth less than normal.) With an income of $300,000,000,000, this country could afford to spend at least 6 percent of its income for medical care; and offer a large outlet for our surplus energies. But we shall spend wisely only if we train personnel vigorously, and improve our financing methods.

SUMMARY

1. The administration bill is much to be preferred to the Taft and Hill bills. For it offers close to complete coverage, deals adequately with the crucial problem of expansion of facilities and personnel, and proposes much needed organizational improvement. The control rests, moreover, with the public, not with those who sell the services. As in education where the control is not by the teachers, so in medicine the control should not be with the sellers of the services.

2. The crucial issue is whether we are to have systems under which the 80 percent, with incomes of less than $5,000, are to be protected against the accidents of sickness by a contributory insurance plan or whether (as under the Taft and Hill bills) the money is to be spent on a charitable basis for the benefit of those who claim need. Our social-security program rests on the self-respecting principle that those who contribute receive benefits as a right.

3. In the past, the number of doctors and dentists trained has been inadequate. The medical schools have been turning out about 5,000 graduates per year over a period during which our population almost doubled and our money national income rose by 10 times and the income in goods by 5 times. In fact, as a result of the small increase in practitioners, the country spent a much smaller proportion of its income on medicine in 1948 than in 1929 or 1933.

Senator MURRAY. That is notwithstanding the fact that medical fees have been greatly increased?

Mr. HARRIS. Yes, sir; they have.

Senator MURRAY. So that there is a lack of real medical care?

Mr. HARRIS. Yes, sir. A further result is large windfall gains for those in this profession. Over a recent period of 17 to 18 years, the income of physicians was up about 150 percent and the rise in numbers but 5 percent. The charge per unit of services since 1935–39 is up by about 35 percent; and the amount of business has greatly expanded. It is imperative to increase the facilities and personnel and to improve organization. This the administration proposes to do.

4. Both from the immediate and long-run economic prospects, it is imperative that the public spend more on services, and especially worth-while services. In this manner, the energies released by increased productivity will be absorbed. The alternatives are wastage in war or in unemployment. This country can afford to increase total expenditures on medicine and health by $2,000,000,000; that is, from 10 to 12 billion dollars in 1 to 5 years and from 12 to 14 billion dollars in 5 to 10 years.

5. It is also necessary to find outlets for the 10 to 15 million college graduates we expect by 1968. Medicine and health now offers employment to 1,000,000; it might well increase the market for college

graduates by 500,000 and thus make an important contribution toward solving one of the most important political and sociological problems facing the country.

6. What we ask is more total income for medicine; better distribution of services; a diversion of expenditures and employment into this important service area. This is partly a medical problem and particularly one of organization; but it is also part of the great economic problem of finding ways to keep our economic machine from collapsing because of its highly productive efficiency.

Senator MURRAY. This program advocated by the administration would result in a great increase in the income of the medical profession?

Mr. HARRIS. Yes, sir; I am sure it would.

Senator MURRAY. And it would distribute the profession around the country to places where the people are not adequately served at the present time?

Mr. HARRIS. Yes, sir.

Senator MURRAY. So you do not find in this bill anything designed to injure the medical profession?

Mr. HARRIS. No, sir; I do not. I find it a little difficult to understand the oposition of the medical profession. I think in general—before I came over here I read the last series of articles in the Saturday Evening Post on medical economics, and the author on the whole does not like this program, but he does say the AMA is to be criticized for having been altogether too inflexible on those matters in the past.

Senator MURRAY. Any questions?

Senator DONNELL. I have just a few questions.

Professor, I did not get to hear the early part of your testimony this morning, because I was somewhat late in getting here. I want to ask you this: You say you are appearing on behalf of the Americans for Democratic Action?

Mr. HARRIS. Yes, sir.

Senator DONNELL. Did that organization take official action in regard to this administration bill?

Mr. HARRIS. Yes, sir. You see, I was the chairman of the domestic platform committee of the national convention this year, and so I was responsible, with the aid of several others, for writing the original draft. We definitely are in favor of the administration program and object to the other proposals as not being adequate.

Senator DONNELL. When was your convention held?

Mr. HARRIS. A month or two ago in Chicago.

Senator DONNELL. Do you recall which it was, whether 1 month or 2 months?

Mr. HARRIS. April 10.

Senator DONNELL. I call your attention to the fact that what you term the Taft bill, namely, S. 1581, was introduced into the Senate on April 14. Had you had the benefit of seeing that bill?

Mr. HARRIS. Not on April 10, but we had read reports about such a bill.

Senator DONNELL. You had read reports in the newspapers about the bill?

Mr. HARRIS. Yes, sir; but we have read the bill since.

Senator MURRAY. A similar bill was filed last year?

Mr. HARRIS. That is right.

Senator MURRAY. And you knew about the proposals?

Mr. HARRIS. Yes, sir; I went through all those hearings.

Senator DONNELL. Have you examined S. 1581? Have you actually read it?

Mr. HARRIS. Yes, sir; I have it and I have marked it. I got it yesterday and read it with considerable care. I had summaries of it before, and I would not say I could reproduce the whole argument, but I would say I read the bill twice.

Senator DONNELL. Read it twice?

Mr. HARRIS. Yes, sir.

Senator DONNELL. On April 10 when your domestic platform was in process of preparation at the convention, you, of course, had not seen anything except newspaper reports of this bill; is that right?

Mr. HARRIS. Yes, sir; that is right.

Senator DONNELL. Then you had seen the bill last year?

Mr. HARRIS. Yes, sir.

Senator DONNELL. Are you able to tell us the differences between those bills?

Mr. HARRIS. Which bills?

Senator DONNELL. The Taft bill of last year and the Taft bill of this year.

Mr. HARRIS. Let me see if I could. I doubt that I could. It seems in general they were somewhat similar.

Senator MURRAY. Last year's bill purported to give medical care to all the people of the United States and this bill eliminated that provision? Is that one difference?

Senator DONNELL. With due deference to the chairman, I wanted to interrogate the witness as to his recollection. It was kind of Senator Murray to assist the witness.

Mr. HARRIS. I went through those five volumes of hearings last year, and I know you are a very vigorous Senator on such occasions.

Senator MURRAY. I want to compliment the Senator. I think he is one of the best cross-examiners I have ever come in contact with.

Mr. HARRIS. I was warned about that.

Senator DONNELL. I appreciate the compliment very much, but I will say I have been greatly assisted in the past by a lady whom I see in the audience here, Dr. Shearon, who was very helpful in providing me with material in regard to this matter.

Senator MURRAY. The material has not been very well selected and it has had a tendency to confuse.

Senator DONNELL. It has been very helpful, and I am grateful to Dr. Shearon for her assistance.

Mr. Harris, I missed the early part of your testimony. I want to ask you about this organization, Americans for Democratic Action. Was it in Cleveland that it met?

Mr. HARRIS. Chicago.

Senator DONNELL. And what is that organization? You say it is an organization of progressives.

Mr. HARRIS. Yes, sir.

Senator DONNELL. You say it is an organization of progressives dedicated to the achievement of freedom and economic security through education and democratic political action. In connection with that word "democratic" could you tell us, please, something of the composition of the organization? Are there many members of the Republican Party in it?

Mr. HARRIS. There are some Republicans, but not a great many.

Senator DONNELL. Not a great many?

Mr. HARRIS. That is right.

Senator DONNELL. How many persons were there at the convention?

Mr. HARRIS. A very large crowd was at the convention. My guess would be about a thousand.

Senator DONNELL. How large a committee was this committee of which you were the head?

Mr. HARRIS. The domestic committee was about 15.

Senator DONNELL. About 15?

Mr. HARRIS. That is right.

Senator DONNELL. You were the chairman of that committee?

Mr. HARRIS. Yes, sir.

Senator DONNELL. And as such you prepared in advance, did you not, a draft of the platform and brought it with you to the convention in Chicago?

Mr. HARRIS. Yes, sir.

Senator DONNELL. That platform, do you have a copy with you this morning?

Mr. HARRIS. It is being printed now, and I will be glad to see that you get one.

Senator DONNELL. Will you be kind enough to file one with the committee, and may I ask, Mr. Chairman, if that may be accepted by the committee and, incidentally, about how large a document is it?

Mr. HARRIS. Several thousand words.

Senator DONNELL. I will not ask at this time that it be incorporated in full, but I would like to have the permission of the Chair to have such portions of it incorporated into the record as are deemed to be pertinent.

Mr. HARRIS. The section on social security includes health.

Senator MURRAY. It will be accepted.

Senator DONNELL. You spoke of the authorship of 21 books, the latest being Saving American Capitalism. Have you expressed yourself on the subject of socialism?

Mr. HARRIS. Yes, sir; and I am against socialism. I would not write a book on Saving American Capitalism if I were for socialism.

Senator DONNELL. I understand that. And you have written this book, Saving American Capitalism, in which you advocate doing certain things you think should be done for the preservation of the capitalist system?

Mr. HARRIS. Yes, sir.

Senator DONNELL. You speak of having in preparation a book entitled "Economics of Medical Care."

Mr. HARRIS. Yes, sir.

Senator DONNELL. Have you been over to England personally?

Mr. HARRIS. No, sir; I have not visited any foreign country to study medicine.

Senator DONNELL. Have you studied the regulations issued by the British authorities in regard to the administration of the medical plan?

Mr. HARRIS. I have done quite a bit of reading on the British episode.

Senator DONNELL. Do you remember a volume possibly 2½ to 3 inches thick, a bound volume, containing various regulations which are used in the carrying out of the British system of medical insurance?

Mr. HARRIS. No; I have never seen that.

Senator DONNELL. You have never seen it?

Mr. HARRIS. No; but I have been through an awful lot of stuff on British medical insurance.

Senator DONNELL. But you have never seen the official book of regulations issued in England?

Mr. HARRIS. I will do that before I finish my book. I wish you would give me an exact reference.

Senator DONNELL. We can give it from the previously published hearings before this committee. In fact, we had the book here, and I would judge it weighed conservatively a pound and a half or maybe more than that. And it is official, as I understand it.

Mr. HARRIS. I still have not written my chapter on British medical insurance, but I will send you a copy of my book because I would like to convert you.

Senator DONNELL. I would be glad to have it.

Senator MURRAY. As I understand it, that book of regulations had reference to the act that was in operation prior to the present act that has been put into effect in England, was put in just last year.

Senator DONNELL. I think that is certainly true, but I have no doubt they have regulations at this time. I cannot conceive that they have abandoned their regulations. I wanted to find out how familiar the professor is with the English system, and I take it you will agree that in order to have real familiarity, you would have to see the regulations under which it operates, would you not?

Mr. HARRIS. Yes, sir, I would agree. May I make a further comment?

Senator DONNELL. Yes.

Mr. HARRIS. I read some pamphlets the AMA put out on British health insurance. Those articles were done by a former student, a Ph. D. in economics. I vouch that I know much more about medical economics in Britain than these articles show. There are a great many people who know more about British medical economics than I do, but I would say that I know a great deal.

Senator DONNELL. Thank you for that information, but what I wanted to find out was, first, how much you actually studied the British system. You have not written your chapter on that?

Mr. HARRIS. No, but I have done a lot of work on it.

Senator DONNELL. Have you written your chapter on New Zealand?

Mr. HARRIS. I have not, and I am not going to write one on New Zealand.

Senator DONNELL. Why are you not going to write one?

Mr. HARRIS. Have you ever had any dealings with publishers?

Senator DONNELL. No.

Mr. HARRIS. Publishers do not like books of more than 200 pages.

Senator DONNELL. You are aware they have had considerable experience there, are you not?

Mr. HARRIS. They have had a program since 1941, and I know something about it.

Senator **Donnell**. You know they have had numerous difficulties in New Zealand, do you not?

Mr. **Harris**. May I elaborate?

Senator **Donnell**. Do you know that?

Mr. **Harris**. Of course, but I would like to say——

Senator **Murray**. You may answer questions in your own way.

Senator **Donnell**. I would like to have the answer and then you may elaborate.

Mr. **Harris**. You are not nearly as tough on the witness as I was afraid you might be. You are much more decent about it.

Senator **Donnell**. Thank you.

Mr. **Harris**. Do you mind restating your question?

Senator **Donnell**. The question was whether or not you are familiar with the fact that in New Zealand they have had various difficulties in the administration of the medical program.

Mr. **Harris**. Of course they have had, and there have been a great many complaints. I just want to show you how this thing works. I have been reading these articles in the Saturday Evening Post and the AMA stuff on the British situation. The complaint there is that doctors are not paid enough. It may well be. Mr. Bevin is a very tough man. He has probably made many mistakes, I would not deny it, but the complaint is that doctors do much more work and get less pay.

When you look at the whole income structure of England, it is not so serious. The complaint in New Zealand is that doctors get too much money. You have either got to get too much or too little. It is almost impossible to get the right amount of remuneration for the doctors.

Senator **Donnell**. You are not going to have a chapter in your book on New Zealand?

Mr. **Harris**. No; I am just going to have one on the British experience, and I am going to concentrate on the domestic problem.

Senator **Donnell**. And you will take up these different bills?

Mr. **Harris**. Yes, I will; and, frankly, Senator, my interest in this is as an economist, and there is an awful lot I do not know about medicine, but I will say I have not seen many doctors who know much about economics.

Senator **Donnell**. Each field is a specialized field.

Mr. **Harris**. Yes, sir.

Senator **Donnell**. Have you read S. 1679?

Mr. **Harris**. The administration bill?

Senator **Donnell**. Yes.

Mr. **Harris**. Oh, yes.

Senator **Donnell**. That was not published at the time of your meeting in Chicago?

Mr. **Harris**. There was a series of bills of this kind.

Senator **Donnell**. Yes, there have been, but S. 1679 was not published at the time of your meeting in Chicago.

Mr. **Harris**. That is right.

Senator **Donnell**. Did your platform declaration take up the Administration measure and advocate it?

Mr. **Harris**. Senator, you are a much more experienced politician than I, and you know you cannot put much into a platform.

Senator DONNELL. A good deal goes in sometimes. I am asking you: What did go into yours? Did you make any comment on the Government program in your platform?

Mr. HARRIS. Yes, we approved it, and the President made it clear to the Nation.

Senator DONNELL. You were not referring to S. 1679, because it was not presented until 15 days after your convention convened.

Mr. HARRIS. That is right.

Senator MURRAY. You were thinking of the program advocated by the President and carried into effect when this bill was filed?

Mr. HARRIS. Yes, sir.

Senator DONNELL. Now, Professor, I have just one or two questions here. You say over on page 10 that the current situation, decline in output, rise of unemployment, reduction of investments, inclusive of inventories, failure of recovery in April, all suggest a recession in 1949.

Mr. HARRIS. Yes, sir.

Senator DONNELL. Do you still think that?

Mr. HARRIS. I still think that, but you know how I feel about economists and forecasting, and I am sure I know how you feel about it, but I think myself you have to make forecasts, as bad as they have been, and I might say I am merely quoting here the National City Bank Bulletin very largely, and I think my forecasts would agree pretty much with theirs.

The situation is not serious, but there certainly is a recession and I think it will get worse unless we get away from this general idea that the thing to do now is to cut spending.

Senator DONNELL. If there is a recession, there would be a recession in national income, would there not?

Mr. HARRIS. Yes, sir.

Senator DONNELL. You say in here that these various things you mention all signify a recession in this very year, and then you say that that might snowball unless strong measures are taken.

Mr. HARRIS. Yes, sir.

Senator DONNELL. I notice over on page 12 of your statement that you refer to the certainty—you say that we can certainly look forward, if we are spared a major war and experience good management, to a national income of $300,000,000,000 by 1965. You say that is a rate of growth less than normal.

Mr. HARRIS. Yes, sir.

Senator DONNELL. Then you say that with an income of $300,000,000,000, this country could afford to spend at least 6 percent of its income for medical care. That would be $18,000,000,000; is that right?

Mr. HARRIS. Yes, sir.

Senator DONNELL. Suppose, Professor, that your view that a recession is suggested and one that might snowball unless strong measures are taken, suppose such a recession occurs and instead of a national income of $300,000,000,000 by 1965, there is a national income of only $200,000,000,000 by 1965.

Would you advocate a cut then in the medical expenditures or would you anticipate we should spend $18,000,000,000 a year with that reduced national income?

Mr. HARRIS. I could answer that well by reading a short letter I wrote to the New York Times which was published a few days ago.

Senator DONNELL. We will be glad to have that go in, but I wonder if you could not answer the question first and then read that.

Mr. HARRIS. Yes, my answer would be that what we have to worry about much more than the Government's budget is a fall of income.

Now, for example, people are saying, "Now, let's cut our expenditures by a couple of billion dollars."

Now, I would say that at the present time if I were a dictator—and, I suppose, it is very lucky I am not—that we should spend 5 or 10 billion dollars more. That means an increase of total expenditures on the budget of one or two hundred million dollars a year. Now, if we did that, we might very well stop a decline of national income of 20 or 30 billion dollars.

My argument is it is much more important for the Government to spend a few billion dollars and prevent a much more serious decline in national income than it is to withdraw spending at a time when income is falling.

Senator DONNELL. Professor, that, of course, was not the answer to the question I asked. What I wanted to get at is this, to boil it down: You talk about here with an income of $300,000,000,000, you say this country could afford to spend at least 6 percent of its income for medical care, and that would be $18,000,000,000.

Mr. HARRIS. Yes, sir.

Senator DONNELL. I assume you think $18,000,000,000 is a reasonable sum for medical care in this country.

Mr. HARRIS. Yes; I would say that if we have an income of $300,000,000,000, we have to find ways of spending that $300,000,000,000, and the way our machine produces goods, you are not going to spend it on manufactured goods, and you have to spend it on services, and health is a very desirable outlet.

Senator DONNELL. I am not speaking of a means of getting rid of surpluses in order to avoid saving amounts of money. I am talking about what is going to happen if instead of having $300,000,000,000 of national income, which would at 6 percent give us $18,000,000,000 for medical expenses; suppose that your anticipation here that we will have a recession that might snowball, beginning this very year, what is your judgment of what will happen with regard to the provision of money for an $18,000,000,000 outlay in the event we go down to $200,000,000,000, or rather we do not get above $200,000,000,000, instead of arriving at $300,000,000,000 of national income?

Mr. HARRIS. If we do have that kind of depression, we will need more spending, more help to get adequate health expenditures.

To put it this way: In 1932 we had $40,000,000,000 of income. Now we have $225,000,000,000 of income. What explains the difference? Do you think it is the management of business? Business, of course, turned out the goods, but there is no use turning out goods unless you get people to buy these goods, and the increase of national income from 40 to 225 billion dollars is largely a product of Government spending more than anything else.

Senator DONNELL. Professor, perhaps I am just dense on it, but I cannot see that you have answered my question. You have given us observations. Let me ask you again.

Do you think $18,000,000,000 is reasonably needed to carry into effect the Administration program for medical care per year?

Mr. Harris. I am not saying that. My recommendation up above was that by 1960 all you would need would be 12 to 14 billions, not only insurance but every other kind of Government expenditures, and that is a very inflated estimate, if anything.

Senator Donnell. You think 12 to 14 billion dollars is needed for various medical expenses, hospital, and dental provisions for this Nation?

Mr. Harris. I think by 1960 we could very advantageously spend 12 to 14 billion.

Senator Donnell. You think it would be useful to spend that amount by 1960. Now, Professor, if this bill is passed, the people of the country are going to be promised what is in this bill. That is right; is it not?

Mr. Harris. Yes, sir.

Senator Donnell. And you think that 12 to 14 billion dollars, as I infer, could be reasonably used in carrying out the purposes of this bill; is that right?

Mr. Harris. I think——

Senator Donnell. Is that right?

Mr. Harris. Yes, sir; I think we could spend 12 to 14 billion dollars very advantageously. That is not very much more than is being spent now.

Senator Donnell. You think we could spend that advantageously in carrying out the purposes of S. 1679?

Mr. Harris. Yes; if you accompany it by proper measures for training people.

Senator Donnell. Instead of having $300,000,000,000 national income, we have only $200,000,000,000. Do you think we could carry out the promises to the people that are made in S. 1679 in that case?

Mr. Harris. I think if we have a $200,000,000,000 income say by 1965, I say here instead of $300,000,000,000, that will be relatively a depression era because it is substantially less than we have now with a population of a good many millions more, and an increase in productivity and a $200,000,000 income in 1965 may find 10 or 15 million people unemployed, which would be serious.

In that situation I would not take strong measures to cut public spending.

Senator Murray. In that kind of situation the scale of prices would go down tremendously; is that right?

Mr. Harris. Yes, sir.

Senator Murray. So that $18,000,000,000 at this time compared to the same amount at that time would show a considerable difference?

Mr. Harris. Yes, sir.

Senator Donnell. You are not answering the question.

Mr. Harris. I am sorry.

Senator Donnell. We have a bill here, S. 1679, the administration bill, which contains certain promises to the public. Is that right? We agree to that?

Mr. Harris. Yes, sir.

Senator Donnell. Now, as I understand it, you think that 12 to 14 billion dollars is a reasonable figure to anticipate to carry out those promises. Is that your opinion?

Mr. **Harris.** No, sir.

Senator **Murray.** He did not say that.

Senator **Donnell.** Let the the witness answer that.

Senator **Murray.** You are trying to misrepresent his testimony.

Senator **Donnell.** I certainly am not. I am asking him if he says that.

Mr. **Harris.** I am not speaking for the administration. I am not speaking for anybody except the ADA. I am a college professor with views of my own. I have consulted the ADA about my views. The administration, as far as it appropriates money, et cetera, as the administration representatives said, the amount involved at the present time is only a billion or a billion and a half dollars more of Government money, and the rest is a substitution of pay-roll taxes as one means of financing this as against private expenditures.

Senator **Donnell.** Let me ask you this. Have you made any estimate at all as to how much it is going to cost per year, regardless of where the money comes from, to carry out the promises contained in S. 1679 to the people of this country? Have you made any estimates?

Mr. **Harris.** Why should I?

Senator **Donnell.** Have you made any?

Mr. **Harris.** I have made estimates of my own.

Senator **Donnell.** What have you estimated would be necessary in order to carry out the promises made in S. 1679 by the year 1960?

Mr. **Harris.** Why don't you go back to the estimates made by Mr. Ewing in the Nation's Health?

Senator **Donnell.** Professor, you asked me why I don't do it. I want to get your ideas, not Mr. Ewing's.

Mr. **Harris.** I am being more liberal with the Government's money than the administration is.

Senator **Donnell.** I will admit you are pretty liberal, that is true, but what I am trying to get at is this: This is the last time I am going to ask you. Have you made any estimate at all as to how much is going to be necessary for the Government to spend, regardless of where the money comes from, taxes, imposts, duties, whatever and wherever it comes from, in order to comply in the year 1960 with the promises in S. 1679? Have you or not?

Mr. **Harris.** I would say this particular bill does not involve larger expenditures in the next few years than you have.

Senator **Donnell.** Have you made an estimate?

Mr. **Harris.** I have made my own estimate.

Senator **Donnell.** What is it for 1960 for S. 1679?

Mr. **Harris.** If you will let me explain it——

Senator **Donnell.** Can you tell us how much would be required, in your opinion, for the United States Government to expend from all sources, taxes or whatever the source may be, in the year 1960 in order to comply with the promises made in S. 1679?

Mr. **Harris.** My honest estimate is that in 5 years you need 1 to 2 billion more and 5 years after that 1 to 2 billion additional and 1 to 2 billion on burial expenditures, which is a very important matter.

Senator **Donnell.** You say near the bottom of page 12 and at the top of page 13 that the control under the administration bill rests with the public. You are familiar with the fact that the Social

Security Administrator is given considerable power of control in S. 1679?

Mr. **Harris.** I realize that.

Senator **Donnell.** That is all, professor.

Senator **Murray.** Thank you for your statement, professor. You will furnish us with the different documentary material that has been requested?

Mr. **Harris.** Yes, sir.

(The following document was subsequently submitted for inclusion in the record:)

THE COSTS OF HEALTH INSURANCE

(By George Soule)

(Prepared and published under the auspices of the Committee on Research in Medical Economics, Inc., New York, and the Public Affairs Institute, Washington, D. C., April 1949)

Committee on Research in Medical Economics, Inc.

1790 BROADWAY, NEW YORK 19, N. Y.

Michael M. Davis. *Chairman*

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Foreword

There has been widespread popular and professional interest in President Truman's proposal for a Nation-wide system of health insurance, and strong differences of opinion about it. One of the chief issues is the cost to be expected. Widely varying estimates of the cost have been published by different organizations, often without explanation of the assumptions and calculations on which their figures were based.

Hence it seemed to the officers of the Public Affairs Institute and the Committee on Research in Medical Economics that a careful review of some of these estimates, by a competent economist, would be of present value to all interested parties. We therefore engaged Mr. George Soule, well known as a student, teacher, and writer on economic subjects, to undertake this task. Mr. Soule has reviewed estimates of the present and future cost of a comprehensive health-insurance plan covering all or a large part of the population, and has also analyzed the economic effects of health insurance upon workers, employers, and upon the economy of the Nation as a whole, in times of full employment like today and in periods of depression.

In enlisting Mr. Soule's services, we have given him full freedom to deal with his subject as he thought best. His analysis and conclusions are his responsibility. We have studied them carefully and believe them to be sound. We consider that they will be useful to those who start by disagreeing or agreeing with them, as well as to those who approach the subject objectively. We commend his study of the costs of health insurance to the attention of the medical profession and the public.

MICHAEL M. DAVIS, Ph. D.,
Chairman, Committee on Research in Medical Economics.
DEWEY ANDERSON, Ph. D.,
Executive Director, Public Affairs Institute.

THE MAIN QUESTIONS

The proposal to add medical care to the social-security program is often criticized on the ground that the cost would be too high. What are the facts on which such a decision may be based? How much would insurance of medical care cost? How can we judge how high that cost is?

The aim of this pamphlet is neither to advocate nor to oppose national health insurance. But anyone weighing the proposal must consider its costs. There are other questions which ought to be considered also. Here costs alone are discussed.

I. WHAT COSTS ARE TO BE MET?

The national health-insurance bill now before Congress would pay, out of the insurance funds, for the following services to insured persons and their dependents.

1. Physicians' services in office, home, and hospital—both general practitioners' and specialists'.
2. Hospital care, including all customary general hospital services for not more than 60 days of hospitalization a year for any one person. Not covered are cases in mental and tuberculosis institutions, or mental and tuberculosis cases in general hospitals for more than 30 days after they are diagnosed.
3. Dental care, limited to partial service, with a priority for children, depending on what Congress may appropriate from general revenues for this purpose. (There are not nearly enough dentists to supply complete service to everybody.)
4. Home nursing, limited service, on the recommendation of the attending physician; also dependent on appropriations from general revenues. (There are not enough nurses to give complete home bedside service.)
5. Essential laboratory and related services.
6. Prescribed medicines which are unusually expensive.
7. Prescribed appliances such as eyeglasses, artificial limbs, braces, etc.

The bill also provides for grants to medical practitioners for attending postgraduate and refresher courses; grants for education in fields where shortage of personnel exists; grants for experiments in prevention, diagnosis, and therapy of disease. These aids would improve quality of care and encourage doctors to settle in areas where such opportunities are not now available.

II. THE PRINCIPAL ESTIMATES OF COSTS

All cost estimates are necessarily tentative; we cannot tell in advance exactly what the bill would be. The estimates vary considerably; those who oppose the measure tend to place the cost higher than those who support it. Only a look at the methods by which these estimates are derived can show why they differ.

The estimate of the Social Security Administration

The Bureau of Research and Statistics of the Social Security Administration has made a detailed estimate of the cost of a system not greatly different from that embodied in the present bill.

The possible service by doctors is limited by the number of doctors in existence. The average gross income of the existing doctors is estimated. Since not all the time of all doctors has been occupied, an extra income is allowed for the additional time of service which might be expected under health insurance. This additional income is estimated at about 25 percent. In return, the Nation would get about 25 percent more medical care than at present.

The average gross income which it is expected that doctors will earn under the system in its first year thus becomes about $13,000 for the general practitioner and $26,000 for specialists, at late 1948 price and income levels. Naturally, in actual practice there would be a wide variation of income among physicians. The most recent figures show gross incomes ranging from a few of $100,000 or more at the top, down to some of $3,500 or less.

Once the figure of average income to be received by the physician is known, the cost per insured person can be estimated by dividing this income by the average number of persons per doctor. The cost per capita of the population (or of any insured portion of it) can thus easily be computed, and the total national cost of physicians' services will be the per capita cost multiplied by the number of people included in the insurance scheme. An allowance is made for cost of administration.

This method of calculating the cost of payment to doctors has certain important implications. If the estimates are about right, the total cost cannot be higher unless, first, the number of doctors increases, or, second, their incomes become higher than those which now would be received if they were all busy.

Since the number of doctors cannot be increased on short notice, the cost of their services during the first year or two after the application of the plan cannot be larger than that estimated by the Social Security Administration unless they are to be paid at higher rates than at present. Estimates of those who believe that the cost of national health insurance would be too high are illustrations of this fact. For instance, an estimate recently released by the Amercan Medical Association implies, after all other possible expenditures are accounted for at going rates, that the physicians in the United States would be paid an average gross income of $80,000 a year under national insurance for medical care.[1]

Again, the cost of dental service as estimated by Elizabeth Wilson in the National Industrial Conference Board study discussed later, would yield dentists an average gross income of $27,000. This estimate is analyzed in more detail in a subsequent section.

Hospital costs

Hospital benefits are limited by the number of hospital beds available in each locality. The payment for hospital service is calculated on that basis. It is higher than the amount now actually being paid, since it is assumed that wherever there are vacant hospital beds, these would be used much more nearly to capacity if the cost were to a large extent prepaid by insurance.

The costs of dental service and home nursing care are estimated by a process similar to that used for services from doctors of medicine. Since only limited services of these kinds can be provided, arbitrary total amounts are estimated for inclusion in the cost figures, and these amounts constitute limits on the expenditure permitted by the bill.

Laboratory services can be roughly estimated. As for medicines, only some unusually expensive medicines prescribed by attending physicians are included in the bill. An allowance is made for such medicines.

In the case of appliances, physicians' prescriptions would also be necessary, with some limitation on the amount that could be insured in payments for such things as eyeglasses.

The costs, estimated by the Social Security Administration as described above, are as follows for late 1948:

	Millions of dollars
Physians' services	2,459
Hospital service	1,804
Dental care	531
Home nursing	86
Laboratory, medicines, appliances	560
Research and education	19
Total	5,459
Per capita [1]	37.39

[1] The average cost for each member of the civilian population, assuming that everybody is included in the insurance plan. The costs were originally estimated as of about December 1945. Subsequent price increases have been accounted for by increasing the original figures according to the price changes for the various items shown by the Consumers Price Index of the United States Bureau of Labor Statistics between December 1945 and September 1948. Two other methods used by the Bureau of Research and Statistics of the Social Security Administration to estimate present costs show somewhat smaller totals than those here given, and somewhat different amounts for the various services.

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[1] See letter of Michael M. Davis to editor of the New York Times, March 3, 1949.

The National Industrial Conference Board estimate

In 1947, the National Industrial Conference Board, a research organization of employers, published a study by Elizabeth W. Wilson, Compulsory Health Insurance, which arrived at an estimate of cost about twice as high as that made by the Social Security Administration as of December 1945. At present, the Social Security estimate is higher than at the end of 1945 because of the rise in prices, but presumably Miss Wilson's estimate would also be increased if brought up to date. Let us compare her figures, item by item, with the official ones of about the same date (not with the figures in the preceding table, which are for 1948).

She estimated a lower annual payment to doctors for each person insured—$12 instead of $14.58 as in the Social Security study. This is because she believed doctors would earn no more if there were medical insurance than without it. Apparently her belief is based on the assumption either that doctors had no idle time or that those who did have it would not have any more patients, even if all prospective patients could afford to go to them. Apparently also she failed to take into account that under insurance many charity and other services now rendered without charge would be paid for.

The cost of hospital services was estimated by Miss Wilson as $12 per person instead of $7.19 as by the Social Security Administration. Part of this addition is due to the fact that she allowed for a rise in daily costs of caring for hospital patients since the 1945 Social Security figures were estimated—a factor accounted for in their most recent figures. The greater part of the difference, however, is based on her assumption that the insured population would get as much hospital care as a celebrated study by Dr. Lee and Dr. Jones concluded would be adequate. The Social Security Administration, on the contrary, did not use the Lee-Jones standards because there are not yet nearly enough hospital beds to provide the amount of hospitalization called for by the Lee-Jones study.

One wonders why in the matter of hospitals Miss Wilson took a position exactly the opposite of that which she adopted concerning the employment of doctors. While she assumed that, under health insurance, existing doctors would serve no more patients than at present, she also assumed that existing hospitals could provide not only more hospitalization than at present, but all that is needed under an ideal standard, a standard for which bed capacity is not sufficient.

For dental services, Miss Wilson allowed $15 a person insured instead of $3 as in the Social Security estimate. This figure is based on reference to a private study of the costs of dental services. The amount of service was that received by a group of 485 white-collar workers in New York City and the estimated payments were based on the fee schedule of the Veterans' Administration for such services.

A footnote indicates that the author of this study, Dr. J. E. Bagdonas, secretary of the committee on economics, American Dental Association, warned Miss Wilson in a letter, "There is some possibility that they [the patients in New York] do not represent a sample of all social and economic groups in the proportion in which they exist over the entire country. * * * Other studies have shown that the actual maintenance needs may be distinctly different from those revealed in this study."

Since there were at the beginning of 1946 about 77,000 dentists in the country, a payment of $15 for each person in an estimated population of 140 million would have produced a gross income of about $27,000 for the average dentist——a sum which is two or three times as much as that actually received. There is therefore little doubt that Miss Wilson greatly overestimated the amount of additional service which the existing dentists could provide and allowed for much larger payments than would be required to engage their services. The pending bill does not provide services on any such scale. Dentists' services to be met under the insurance plan are strictly limited, not only by the insufficient number of dentists, but by the fact that the bill does not allow the Government to appropriate more than at first one-half of 1 percent, and later 1 percent of the social-security-taxed wages received annually to cover dental care, home nursing, and certain other expenses.

For home nursing services Miss Wilson estimated a per capita cost of $1.25 as against the 51 cents allowed by the Social Security study. The difference appears to be due to the fact that she assumed that half the required personnel would be graduate nurses and half practical nurses, whereas the official study used the ratio of one graduate nurse to two practical nurses. Of course, the salaries of graduate nurses are much higher than those of practical nurses. Evidently Miss Wilson assumed that more graduate nurses were available for the health-insurance services than did the Social Security Administration, but she did not explain her calculation in detail.

Miss Wilson estimated an expenditure for medicines which would cover all drugs purchased, and in addition allowed a large increase resulting from the introduction of the insurance system. This contrasts with the official plan to pay only for medicines prescribed by physicians, and among these to pay only for the most expensive and the most essential. Miss Wilson's addition increased the official estimate for medicines more than eightfold. The item for laboratory, drugs, and appliances in her estimate thus becomes $14.75 per capita instead of $3.38, as in the Social Security study.

Whether all the services estimated by Miss Wilson could be provided may be seriously questioned. The difference between her estimate of cost and that of the Social Security Administration is accounted for largely by her much more liberal standards of the volume of service, except in the case of physicians. She allowed for hospital care according to an ideal standard, for which not enough hospital beds are available, five times as much dental service as the official plan (or else much higher payments to dentists), more home service by graduate nurses, and all the medications anyone might be inclined to buy. Such extravagant estimates can hardly be an adequate basis for her conclusion that the cost of national health insurance must be too high.

Estimates of future cost

Most other estimates by private agencies of the probable costs of health insurance refer to years so far in the future that it is scarcely worth while to analyze them in detail. All estimators, including those of the Social Security Administration, agree that the cost will increase after the system is established and as the years pass. This increase will be a natural consequence of the hoped-for expansion in the adequacy of medical service, as well as of population growth.

The Tax Foundation, estimating the cost of health insurance for the year 1960, as based on the provisions of the Wagner-Murray-Dingell bill of 1943, arrived at a figure of $3,464,000,000.

Gerhard-Hirshfield, whose figures are reproduced in a pamphlet published by the Insurance Economics Society of America, Social Security Tomorrow, estimates ultimate costs, applicable apparently in 1970–75. The item for health insurance in this publication is $3,000,000,000—considerably smaller than the Social Security estimate for 1960.

A pamphlet by Earl E. Muntz, Proposals for Health, Old Age, and Unemployment Insurance, published in February 1946, summarizes the above estimates, and revises them to accord with the provisions of the Wagner-Murray-Dingell bill of 1945. The Tax Foundation estimate for health insurance in 1960 becomes $3,871,000,000 according to Muntz's revision. The Insurance Economics Society estimate for an ultimate cost of health insurance becomes $3,407,000,000. Both figures are roughly in line with the estimate made in 1946 by the Government, of $3,750,000,000 for 1960, assuming no rise in the price level above that which existed in the early part of 1946, when the Muntz study was published.

To estimate ultimate costs is fruitless without at the same time relating them to the probable national income 10, 15, 20, or more years hence. All such estimates are highly speculative. To make such estimates requires assumptions, for example, as to the number of doctors, dentists, and other personnel we shall decide to train during the next 10 or 20 years; as to the rate of hospital expansion; as to general prosperity or the reverse. Such estimates can scarcely provide a reliable basis for present policy. What the citizens and Congress should consider first of all is the present cost of what is actually proposed in the bill under consideration, and its relationship to the present ability of the Nation to pay that cost. The estimates of the Bureau of Research and Statistics of the Social Security Administration appear to be the most reliable figures available.

III. HOW MUCH ADDITION TO PRESENT COSTS?

What would be the actual cost of health insurance in the immediate future, if the system were installed now? This cost will be estimated first in money, then in terms of manpower.

The cost in money

If a man with an automobile is thinking of buying a new one, he does not regard as the cost to him the whole price of the new car. He subtracts from that price the turn-in value of the one he already owns. Insurance is in large part merely a different way of paying expenses which the population as a whole incurs anyway. It is a redistribution of the burden of existing cost. If doctors and hospitals are paid about the same amounts for the same services as formerly, then only the additional medical service which the population might be expected to use under an insurance system can give rise to additional cost.

If the total estimated cost of medical payments to be met by the insurance system is approximately 5.5 billion dollars a year (as estimated on page —) how much of this would be additional to the medical payments already made by the population for services, the cost of which would be taken over by national insurance?

We cannot use as the basis of comparison everything now spent for medical services, since this includes much that will not be covered by insurance. For instance, people of means rent private rooms in hospitals or pay for special nurses. It is not proposed to insure all the cost of dental service or of all medicines purchased.

The extra service to be paid for

In estimating the cost of physicians' services under insurance, the Social Security Administration assumed that doctors as a whole have enough extra time so that they could earn 25 percent more than at present, at the same rates of remuneration. It was also assumed that hospitals have enough unused space so that they could provide somewhat under 25 percent more service than now—perhaps 10 percent more in the first year of operation of the new system. For this they might have to spend 10 percent more than at present to make their services more adequate.

There is a greater shortage of dentists than of physicians; and the bill strictly limits the total of dental service to be paid for out of insurance. It is doubtful how much additional home nursing service might be available; certainly not much more than is now engaged. Medicines, laboratory services, and appliances of the sorts allowed for under the pending bill might be bought in greater quantities by the insured. It might be reasonable to allow an increase for them of not more than 50 or 100 percent. Since insurance payments would cover only medicines, laboratory services, and appliances recommended by attending physicians, the increase would scarcely be higher than this.

In order to be certain that we do not underestimate the extra service which would be rendered, let us say that the total amount to be paid under national medical insurance for the first year or two of operation would be 25 percent greater than the present payments for the services to be insured.

It should be noted that in health insurance there will be no accumulation of a large reserve as may be in unemployment insurance or old-age insurance. Everything collected from the public will be paid out currently, with the exception of a small fund of working capital, and a small reserve to smooth out year-to-year fluctuations.

How much is 1.1 billion dollars?

Just as the automobile buyer turns in his old car in part payment for his new one, the American people would thus "exchange" medical service now received for a somewhat larger amount of service. The cost of this larger amount is estimated at 5.5 billion dollars. Since this is approximately 25 percent greater than the cost of similar services now paid for by the insured, the net money cost would be the difference. This would be 20 percent of 5.5 or 1.1 billion dollars for 1 year. This cost arises, solely on account of the additional services which the insurance might immediately provide, because it would enable people to pay who now cannot afford to do so. The people of the country would get, in return, 25 percent more medical care.

How much is 1.1 billion dollars? When a man buys a car, if he budgets carefully, he gets an idea of the size of the cost by comparing it with his total expenditures for the year. During the second half of 1948, the American Nation as a whole was spending at the annual rate of 257.8 billion dollars for all the goods and services which they bought, including medical care. If they had laid aside enough of this sum to pay the extra cost of the proposed medical insurance, they would thus have decreased their expenditure for nonmedical goods and services by less than one half of 1 percent. Since the figures are at best rough approximations, this is sufficient to indicate the order of magnitude. The precise ratio which this estimate of medical insurance cost bears to the total gross national product (in money terms) is 0.427 percent (427 thousandths of 1 percent).

When anyone asks whether the Nation can afford to pay for health insurance, he is therefore asking whether it can afford to devote to this service less than half a cent out of every dollar spent. Do the citizens want the new system that much? That is the relevant question.

IV. COSTS IN MANPOWER AND IN GOODS

It is sometimes more realistic to think of costs, not in dollars but in the real resources which have to be devoted to producing the wanted article. In 1948 the United States enjoyed virtually full employment and almost a capacity level of production. Any resources devoted to the immediate increase in medical service must therefore, we might conclude, be taken away from the production of something else. Is this entirely true?

The cost of manpower

As far as the services of doctors, dentists, and graduate nurses are concerned, it is not true. You cannot take a productive worker off a lathe or away from a white-collar job and make a doctor or a dentist out of him. Training such practitioners takes years. Any additional medical service which might be made available during the first year or two of operation of an insurance system would have to be provided by the same number of trained medical workers we should have had in any case, except for some increase in technicians, practical nurses, and relatively unskilled hospital workers. Additional service would arise mainly because the time of professional persons was more completely occupied. In other words, it would constitute a fuller utilization of the time of those already engaged in the professions concerned. Health insurance would not take much manpower from any other pursuit, at the outset.

Nor is it possible to plan, build, and equip a new hospital within a year, unless it is a very small and simple one. The principal increase in hospitalization possible at the beginning of the scheme would arise merely from fuller use of the existing hospital capacity, or capacity of new hospital buildings already nearing completion. There would, however, be some necessary increase in the number of hospital employees.

Therefore, any immediately available extra service would be provided without much extra manpower. It would constitute mainly a gain in the productivity of the working force in medicine.

The cost in goods

But how about the dollars paid for this extra service? Doctors, dentists, nurses, and hospitals would receive money for the additional service which they might provide. They would spend or save this money. Would not their additional spending increase the aggregate demand for the goods which they bought?

Again the answer is "No." The money paid for medical services would come from pay-roll or other taxes on the incomes of those who receive the services.

In other words, the people of the country would be exchanging a small percentage of goods and services which they might otherwise enjoy for the additional medical services which they would be receiving. The existing corps of medical workers would in this way get extra compensation for their additional work.

There would be little immediate cost in manpower or other real resources, to the country as a whole, if health insurance in its first year or two provided more medical service than is now provided without it. The real cost to the insured persons would be measured by the goods which they would sacrifice, that is, the goods which medical workers would be enabled to buy with their extra payments.

V. ABILITY TO PAY FUTURE COST

If adequate care is to be provided in the future, the necessary practitioners must be trained, hospitals built, clinics and health centers established. This would take time. Exactly how much it would cost is difficult to say, except on the basis of experience such as would be accumulated under a health-insurance system. In any case, the change would be gradual.

Increase in cost

The Bureau of Research and Statistics of the Social Security Administration estimated in 1946 that the per capita cost of the benefits provided in the present bill would rise from $28.76 at that time to $38.93 in a future year called 195X—5 to 15 years after the program begins. This increase is allowed solely to account for more adequate service which could be provided by additions to medical personnel and facilities. It amounts to about 35 percent.

In assessing ability to pay this extra cost, we need not consider either the growth of population which is expected or any change in price levels. A larger population would, of course, need more service than the present one, but it would also have a correspondingly larger income with which to pay for it. The fact that the figures are reduced to cost per capita makes it possible to ignore population growth. Since any change in price levels would affect the average money income in about the same proportion as the expense of the service, it is unnecessary to guess at future price changes.

The cost of the medical services to be provided under the bill is estimated at a maximum of about 5.5 billion dollars annually (as of the third quarter of 1948). Add 35 percent to this for the more adequate service which might be available at a future time if enough more doctors, dentists, and nurses had been trained and more hospitals had been built. The addition thus becomes $1,925,000,000—say, in round numbers, $2,000,000,000. The gross national product as of the second half of 1948—which is the money cost of all the goods and services bought in the Nation—was running at the annual rate of 257.8 billion dollars. Thus, in order to provide the extra medical services without decreasing other forms of satisfaction, we should have to increase the national product less than 0.8 percent (eight-tenths of 1 percent).

Meanwhile the national product will increase

But by the time this larger amount of medical service could be provided, the national product is likely to have become considerably greater than it now is. Between 1869 and the decade ending in 1918, the gross output of the economy doubled about every 20 years. Between 1919 and 1929 it grew 33 percent. Little gain was registered in the depression years of the 1930's, but from 1939 to 1948 an advance of 50 percent was made, so that in the 30 years, 1919 to 1948, the gross product doubled again. (The effect of price changes has been eliminated from these figures, so that they represent real gains.)

This gain in output is much greater than the growth in population. While the product was doubling between 1919 and 1948, the population grew about 40 percent. There was thus a gain of about 50 percent per person since the end of World War I.

The President's Council of Economic Advisers estimates that the output per man-hour for the entire economy should grow at the rate of 2½ percent a year for the next few years. The gain in output per man-hour has averaged about 2 percent annually for a long period in the past. An annual gain of 2 percent, compounded, means a growth of more than 10 percent in 5 years, and one of about 22 percent in 10 years.

We can pay out of future production

For every man-hour of work put in by all workers in the United States—including wage earners, farmers, teachers, doctors, and all the rest—the product of goods and services is likely to become at least 10 percent larger in 5 years and 22 percent larger in a decade. We need an addition of less than 1 percent to cover the extra cost of more adequate medical service, as compared with that which now could be provided under an insurance system. Thus, to get the extra service, we shall have to devote to it, as a probable maximum, less than one-tenth of the gain from probable future increases in the efficiency of national production, if we are to achieve the additional medical service in 5 years, and less than one-twentieth of the gain if we are to achieve it in 10 years. (The calculation assumes that the number of persons at work will continue to be as large a part of the population as at present.)

This means that, on the average, the people of the United States can probably have after 5 years (a) as high a standard of living as they now enjoy; plus (b) more adequate medical service; plus (c) a gain of more than 9 percent in other goods and services. If a 10-year period is taken to develop the higher standard of medical service, the average person can have, at the end of the decade, that service plus a gain in other necessities and satisfactions of more than 21 percent. Do the people of the country wish to earmark that much of their ture increase in income for the additional medical care? If so, they can afford it.

The question of allocation of resources

When almost everybody is employed there are only two ways in which we can get more than at present of any service or goods we want. One is to take the manpower away from making other things. The other is to increase the total output by more efficient production or by better allocation and training of the workers.

Spending additional money is not going to increase the goods and services we receive, if the additional goods and services are not there to be bought. Under these circumstances, more money spent merely means higher prices for what we buy.

It is, therefore, necessary to make choices as to how we want to use our productive resources, under a regime of full employment, such as it is the aim of the United States to maintain. The Nation as a whole must do this, just as the individual must choose how he is going to spend his income. We want more food, clothing, houses, automobiles, and many other things. The Government has to buy aircraft, ships, office buildings, soil conservation programs, atomic research, etc. All these demands have to be fulfilled out of the common stock of workers, plants, and raw materials.

In planning for the future, many different kinds of needs are foreseen. In competition with all the other needs, can we afford the manpower required for adequate medical service? Let us get the question into perspective by stating it in terms of manpower.

Medical manpower

In 1940 there were in the United States about 140,000 active physicians. In the same year there were about 70,000 dentists in practice. There were about 370,000 graduate and student nurses. Full-time technical medical personnel in hospitals numbered about 61,000 (in 1945). The total of trained medical personnel was therefore about 641,000. If we make a liberal allowance for workers engaged by doctors and hospitals—secretaries, attendants, engineers, cooks, maids, etc., the total attached to medical service may have been about 1,500,000 persons. The estimate is a rough one, but a difference of a hundred thousand or two one way or another would not greatly affect the issue involved, because any conceivable total of medical workers is small in relation to the number of all workers in the Nation.

In 1940, the total civilian labor force was 55.6 million (of whom 8,120,000 were unemployed). If those engaged in medical service numbered 1.5 million, they constituted less than 2.7 percent of the total labor force. It is probable that in 1948 the percentage was no higher.

Let us suppose that, in accordance with the estimate of the Social Security Administration, the number of medical workers is to be increased so that 35 percent more service per person insured can be rendered than by the present force, if it were used to the fullest efficiency, under national health insurance. Let us further assume that this would require a 35 percent increase in the number of medical workers per person insured. About 3.6 percent of the labor force would then be engaged in medical service as compared with 2.7 percent at present. The required increase in medical personnel would be about 1 percent of the labor force. In terms of our present civilian labor force of about 61,000,000, this would require about 610,000 extra persons.

Could we afford to take that number of persons away from other occupations, in return for a substantial increase in the amount of medical care?

The demand on manpower

In 1940 the reservoir of unemployed was at least five times as great as the total number connected with civilian medical and allied service. If additional qualified persons had been educated for these services, there would have been no lack of other manpower to do the rest of the Nation's work.

In a period of full employment, men and women would have to be diverted from other employment if the percentage of those attached to medical service were to be increased. But the process would be gradual, because of the length of training involved, and the time required to supply hospital and other facilities. In the meantime, the productivity of workers engaged in turning out physical goods would grow, so that a smaller number would be required to provide the goods necessary for a decent standard of living. The chances are that we could easily spare those who would have to be recruited for medical service.

During the decade of the 1920's the physical output of the Nation increased very rapidly. The population grew 9 percent between 1923 and 1929; meanwhile the purchases of consumers grew 23 percent (the effect of price changes being eliminated). Yet during these years there was a 5 percent decrease in the number engaged in farming, an 11 percent decrease in the number employed on railroads, a 24 percent decrease in the number employed in coal mines, and practically no change in the number employed in manufacture (though the physical output of factories grew 30 percent).

About the only net gain in employment between 1923 and 1929 occurred in the occupations engaged in supplying services. If it had not been for the increase of numbers in the service industries, the volume of unemployment would have been much greater than it was in the prosperous 1920's.

It is likely that in the future a considerable expansion in employment opportunity in medical service would fit very nicely with some decline in the need for manpower in the industries supplying material goods. Indeed, the expansion of medical service over the next decade or more might be several times that now contemplated without causing any risk of a manpower shortage in other occupations.

At present there is a good deal of concern whether enough suitable employment opportunities will be open to utilize the skills of those who will probably receive a university education. An expansion of the number of doctors, dentists, nurses, technicians, and other medical personnel would help to supply those opportunities.

VI. NATIONAL HEALTH INSURANCE IN BAD TIMES

How would national health insurance work when prices fall and unemployment increases? Would it tend to retard the downward swings of business or to exaggerate them?

The first point to make about this question is that the plan will be financed by taxes, the proceeds of which will be spent regularly for medical care. Very little money will be collected by the tax which is not paid out promptly—only a small surplus will be retained for working capital.

We might therefore infer that the plan will not have an important effect on the swings of business. This is because most of the money spent to pay for it will be currently collected from those who are covered by the insurance, and must be spent for the purpose—medical service—for which it was collected.

The effect of spreading the cost

One feature of the plan, however, is likely to have some stabilizing effect. People with small incomes will, under it, receive medical service for which they previously did not have the money to pay. The cost of this service (paid out of the insurance fund) will be greater than the payments which would have been made for medical care by families in those lower brackets if there were no national health insurance. Yet they will buy almost as much of other goods and services as they did before. What they spend for food, clothing, rent and incidentals, plus what is spent for their medical care, will be greater under national health insurance than without it.

People in the upper income brackets, on the contrary, will not, as a whole, receive more medical service than before. This does not mean that individual upper income families will not gain from insurance. Those who have the misfortune of serious illness will find their financial burdens greatly lightened, because of the spreading of the risk.

The contributions of all the families in the upper income brackets to the health insurance plan through the pay roll tax and otherwise, plus the additional personal payments which they may make for extra medical service, will be greater under insurance than without it. Their contributions to the insurance fund will be larger, in total, than the cost of the medical care they receive under it. This excess will be utilized to pay for the increase in medical service to be received by the families in the lower brackets.

Families in the lower income brackets usually spend all they receive; there are no net savings in these brackets, if we balance the deficits of those who spend more than they earn against the savings of those who spend less than they earn. All the net savings come from the higher income brackets. In time of depression, therefore, when incomes are falling, those with the higher incomes are likely to save less and spend a larger part of their incomes as they drop into lower brackets. They would be all the more likely to do so if protected by health insurance, since then they would not have to provide against the misfortune of illness.

Thus the effect of national health insurance is likely to emphasize larger spending and smaller saving during depressions. It is at this very time that larger spending and smaller saving are desirable to bolster up employment.

The effect of the Federal appropriation

The greater part of the cost of medical insurance will, under the pending bill, be met out of the pay-roll tax. When a business recession sets in, employment decreases, wages and salaries have a downward tendency. Since pay rolls become smaller during a recession, the yield of the pay-roll tax will be less. This will probably not occasion any great difficulty in a moderate or brief recession, for two reasons. Prices go down as well as incomes, and there will be some fall in the cost of medical service, so that the expense to be met by the insurance fund will decrease as its receipts fall. Insofar as this did not occur, the working capital of the insurance fund would probably be sufficient to bridge the gap.

But in a severe or long-continued depression, with a large volume of unemployment, the pay-roll taxes would probably shrink considerably more than the medical expenses which had to be paid. There would be a deficit in the insurance fund, which would have to be met by enlarging the Federal appropriation out of general funds.

At times when the Federal budget is unbalanced, as it is during depression, the payment from the Government would in part be financed by borrowing. Thus it would fit with any governmental aim to combat depression by a compensatory fiscal policy. When the Government spends money which does not come out of the current income of the public, and so does not reduce the spending of the public, the total of demand is enlarged and employment is stimulated. This would be as true of money spent for medical care as of any other type of expenditure.

Insofar as the Government appropriation to medical insurance increased employment during a depression, the insurance would be costless in real terms. That is, its cost would be counterbalanced by the increase in employment, production and income to which the appropriation gave rise.

This analysis has taken no account of the possibility that national health insurance might reduce the total of diseases and disability. Of, for instance, it made possible the discovery and cure of ailments at an early stage and before serious trouble had developed, it would pay for itself many times over. Many millions of dollars are spent every year in paying the costs of disease which might have been prevented or lessened by diagnosis and treatment in early stages. An enormous number of man-hours of labor are lost to the Nation because of nedless disability. Whether health insurance would facilitate prevention of illness would depend on the quality of medical service available and the efficiency of administration. This is a medical question beyond the scope of the present report.

VII. WHO WOULD BEAR THE COST?

So far, we have discussed merely the total cost of health insurance to the economy as a whole. What the cost to specific parts of the population will be depends on the method which may be adopted to raise the necessary money. In order to simplify this problem, let us assume that the insurance adopted will cover the whole population, with the exception only of those whose medical costs are already met out of public funds, such as the members of the armed forces.

The change in burden due to insurance

The most widely understood feature of the plan is that which is similar to any type of insurance. Without health insurance, the burden of medical costs falls entirely on those who have the misfortune to become ill, unless their expenses are met out of charity. With insurance, this burden is spread over all the insured, so that each pays regularly a small amount. The protection offered under the pending measure is not complete, but if the bill is passed those who need medical attention will generally pay little more than those who do not. Some burden of costs will likewise be lifted from physicians, who need no longer worry over unpaid bills or over the obligation to give some of their effort to charity patients.

But the proposed methods of payment differ in one important respect from that with which we are familiar in ordinary commercial insurance or even in most voluntary nonprofit health insurance plans. Ordinary insurance charges a flat premium or rate for the amount of protection provided, with variations depending on the character of the risk. In group insurance the rate depends on the risk of each group in question. But each of the insured pays the same amount, no matter what his age or income.

The methods proposed by the national plan do not vary the payment in accord with the benefit or the risk, which is spread over all the insured. They do vary the payment in some degree with the income of the insured. However, each person is guaranteed whatever service he may need, within certain maximum limits. In this way national health insurance differs radically from any of the usual voluntary plans. Those who can better afford it will pay part of the cost of medical service for those who can afford less. The service will be rendered according to need; the payment will be made, in larger or smaller degree, according to means. This accords with the principle of sliding scales now general in noninsured payments to private practitioners and hospitals.

Methods of distributing the cost

Three methods are proposed. Any one of these methods might be used alone, but the probability is that they will be used in combination. How they are combined will determine the degree to which payment is adjusted in accordance with ability to pay.

Pay-roll taxes on employees

The first method is to charge the cost to the incomes of the insured by deducting a flat percentage of wages and salaries up to a specified amount—($4,800 a year being proposed). Persons with incomes above this figure would pay the tax only on $4,800. A somewhat larger rate of tax would be levied on the self-employed. The pay-roll tax, implied by the bill, would be about 1½ percent on employees, another 1½ percent being charged to their employers.

That part of the tax deducted from the employee's pay would thus be directly proportional to his income within the range of zero to the ceiling figure enacted ($4,800). (About three-quarters of American families fall below that figure.) The pay-roll tax would not, however, be adjusted to ability to pay to as great a degree as by income taxation, which exempts the lower incomes entirely and assesses progressively higher rates up to the top brackets of income. On the other hand, since persons even of low income spend on the average 3 percent or more of their incomes for medical care, the 1½ percent would not be a new burden.

Pay-roll taxes on employers

The part of the pay-roll tax which employers pay would have different effects at different times or in different circumstances.

Many authorities believe that employers' taxes under social insurance are likely to be shifted to consumers in the form of higher prices. This is particularly true at periods of relatively full employment, when consumer demand is high.

In a highly competitive industry or during a depression, the employer's share of the contribution might not be passed on to the consumer. In that case its effect would be to reduce profits or increase losses. In such circumstances, there might be a tendency for the cost of insurance to reduce the level of employment. But such an effect would probably be minor.

Insofar as the cost is passed on by employers, the employer contribution acts like a general sales tax. It raises the cost of any given article equally to all consumers, regardless of their incomes. This bears more heavily upon consumers with small incomes.

Contribution from general revenues

Part of the cost will be met by contribution from the Federal Treasury; this is likely to be small, according to the provisions of the law. When the Federal budget is balanced, this cost will rest chiefly on the taxpayers, and will be apportioned exactly like any other governmental cost paid out of general revenues. Since the Federal Government derives the greater part of its revenues from the income taxes on individuals and corporations, the burden of the cost would be adjusted to ability to pay to the degree embodied in those taxes.

Any part of the cost borne by Federal income-tax payers would be more fully adjusted to ability to pay than any part of the cost borne by pay-roll taxes on either employee or employer. Yet the part of the cost met out of pay-roll taxes would not increase the burden met at present by families in the lower brackets of income, since they already pay as much or more for medical care as the pay-roll tax would amount to.

VIII. SUMMARY

What costs are to be met?

National health insurance as proposed in the pending bill would cover the costs of general physicians' and specialists' services, of hospitalization up to 60 days a year per person (except in cases of mental disease and tuberculosis), of laboratory services, appliances, and the more expensive medicines prescribed by physicians; and of limited dentistry and home nursing (p. 5).

Estimates of these costs

The most reliable estimate of the total cost to be met for the first year of the plan is about $5,500,000,000 or $37.39 per capita of the population (pp. 6–8).

Higher estimates, which have been made by opponents of national health insurance, would require that there be more doctors, hospitals, dentists, nurses, and other health-service personnel than now exist, or else that payments to these persons would be far above their present earnings (pp. 8–12).

How much addition to present costs?

The actual money cost of the plan to the Nation would be the amount by which the insurance payments would exceed the present costs of the same kinds of services. This excess cost would be about $1,100,000,000. This amount is less than half a cent of every dollar spent in 1948—i. e., it is one-half of 1 percent of the gross national product (pp. 12–13).

How much cost in manpower and in goods?

In terms of demands upon manpower or upon other resources, there would be only very slight cost during a period of full employment (pp. 14–15).

Ability to pay future cost?

The increase in manpower (including all kinds of health-service personnel) which it is estimated would be required in order to supply fully adequate medical services to everybody, would be about 1 percent of the Nation's labor force. The chances are that this number will be more than counterbalanced by the numbers released from the production, transportation, and distribution of material goods, assuming that technical progress makes headway in the future as it has in the past (pp. 19–22).

Measured in terms of national product rather than in manpower, the same increase in personnel and facilities would require less than one-tenth of the expected increase in national product per person during the next 5 years, or less than one-twentieth of the expected increase in the next 10 years (pp. 16–20).

What would happen in bad times?

Health insurance tends toward stabilizing purchasing power among the mass of the people. It tends to emphasize larger spending and smaller saving during depressions, and this is desirable because employment is thus bolstered (pp. 20–22).

Who would bear the cost?

National health insurance would distribute the costs of medical service so that, during any given period of time, those who are ill would pay little more than those who remain well. The effects of unpredictable sickness costs upon families are thus removed.

The pay-roll tax levied upon employees, if of 1½ percent or even somewhat more, would not be a new burden, since families even of low incomes now spend on the average 3 percent or more of their incomes for medical care.

The 1½-percent tax levied upon employers would usually be passed on to the consumer, and would be proportional to the amount spent by the various consumers. The minor part of health insurance costs which it is expected might be met by appropriations from general governmental revenues would be largely adjusted to ability to pay, since the greater part of such revenues are derived from the income tax (pp. 23–25).

Senator **MURRAY**. Dr. Carl O. Flagstad, representing the American Dental Association. Will you take the stand, doctor, and state your name and official position with the American Dental Association?

STATEMENT OF DR. CARL O. FLAGSTAD, MINNEAPOLIS, MINN., ON BEHALF OF THE AMERICAN DENTAL ASSOCIATION

Dr. **FLAGSTAD**. My name is Dr. Carl O. Flagstad. I have been engaged in the private practice of dentistry in the city of Minneapolis, Minn., for 38 years, during which period I also have been a professor in the school of dentistry at the University of Minnesota, where I have served as chairman of the department of denture prosthesis for many years.

The council on legislation of the American Dental Association, of which I am chairman, is elected by the house of delegates and charged with the responsibility of representing the American Dental Association before the Congress of the United States on legislation of interest to dentistry. It is my purpose today to present the views of the association concerning the National Health Insurance and Public Health Act.

Senator DONNELL. That is S. 1679; is that right?

Dr. FLAGSTAD. That is right.

THE AMERICAN DENTAL ASSOCIATION AND ITS OBJECTIVES

The American Dental Association, with its predecessor society, has been the national organization of dentistry for nearly 100 years. Today there are more than 69,000 members of the American Dental Association, or approximately 85 percent of the dentists registered in the United States; in addition, 70 percent of all dental students in schools of dentistry throughout the United States are student members. The association has 53 constituent societies, which represent each of the 48 States, the District of Columbia, each Territorial possession, and dentists employed by the Government of the United States in the Army, Navy, Public Health Service, and the Veterans' Administration. Within the constituent societies there are 433 organized district societies. Each constituent society sends delegates to the annual meeting of the house of delegates, where the policies of the association are established through official actions by the house.

This extensive dental organization was not created to be a dental pressure group. It provides a working medium through which the dentists of this country may study problems relating to dentistry, and to the dental health of the Nation, and through which they may mutually contribute to the advancement of dental knowledge.

The American Dental Association and its component societies are dedicated to the improvement of the dental health of the people of America. That the objectives of the association have been adhered to by the membership is demonstrated by the fact that the United States has the best dental health and the finest dental care for its people of any country in the world.

The association has taken its professional obligation seriously. It has annually expended a goodly portion of its own funds for dental research. It has created and maintained fellowships at the National Bureau of Standards and at the National Institute of Health. It maintains a research commission at the Army Dental Museum, and through its council on dental therapeutics, devotes considerable time and effort to the study, evaluation, and dissemination of information with regard to dental therapeutic agents. Through its council on dental health it continually studies the oral health needs of the public, develops plans to meet such needs, and stimulates programs for promoting oral health. It maintains a comprehensive program of oral health educational services, which are available to the membership and to the public.

Dentists devote considerable time each year in attendance at the meetings of their various dental societies, for the purpose of attending clinics and lectures designed to improve their professional knowledge and skill so that they can more efficiently serve the dental needs of their patients.

Dentists, as individuals, and as a profession, have demonstrated their interest in promoting the better health of the people in the community, in the State and in the Nation. Through the efforts of the dental profession and its associations the dental health of the public of this Nation has constantly improved, and with such improvement in dental health there has been also an improvement in general health.

Dentistry has recognized its obligations. It has developed, fostered, and expanded dental schools for the training of more dentists; it has contributed its funds and time to research projects in an endeavor to better the health of the population; it has encouraged and promoted the establishment of dental health programs for children and adults in hundreds of cities and counties throughout the country. Through its efforts and encouragement, dental divisions have been established in nearly every State health department. The dental profession has consistently examined legislative proposals relating to dental health and has endorsed what it deems good for the dental health and welfare of the people. It has vigorously opposed legislative proposals that it considered not in the best interest of the people.

DENTISTRY'S RESPONSIBILITY

This preliminary statement has been made to assure the Congress that the dental profession is keenly aware of its responsibility in matters pertaining to the dental health of our Nation and to indicate that the American Dental Association has continually stimulated its membership to discharging this responsibility with unselfishness and efficiency.

The dental profession believes it is the rightful guardian of the people's dental health and that the profession is best qualified by training and experience to judge the value of a dental health program for the United States.

The dental profession believes it would be derelict in its duty if it did not oppose health legislation which in its judgment is detrimental to the health and welfare of our people.

The American Dental Association believes this committee and the Congress of the United States will understand that the association, in its opposition to the philosophy of compulsory health insurance, is motivated by the sincerest desire to protect the Nation against a system which the association believes will deteriorate the health services afforded to our people.

The National Health Insurance and Public Health Act is a proposal for a health program which dentistry considers to be unwise legislation. The association believes that the responsibility for providing dental care must be borne in the same manner as the responsibility for providing food, shelter, clothing, or any other essential of life. It is the American custom and tradition for an individual to attempt to supply these for himself. If he cannot do so, the responsibility falls on the family, the community, the State, and the Nation successively. If each assumes an equitable share of the responsibility, the problem of better dental health in this country is on the way to solution. There is no more reason for the Federal Government to assume the primary responsibility for providing health care than there is for it to assume the primary responsibility for providing food, shelter, and clothing to all.

Although it is necessary for the community and Government to care for the health needs of its indigent and to aid those unable to meet the expense of protracted illness, it is a fallacy to assume the collection of money at the Federal level to be channeled into health care will make available adequate health service to everyone and guarantee an improved level of health to our people. Undoubtedly those who are familiar with the problems surrounding the distribution of health care are aware of the limitations of a nationalized health program, but unfortunately the general public believes the proposed compulsory health-insurance legislation is a panacea for the difficulties of the care and expense associated with illness. If the Congress should enact this proposal it will saddle the Government with a gigantic task which it cannot possibly discharge in the manner the people have been led to believe.

LIMITATIONS OF THE PROPOSED ACT

This bill infringes on the rights of the individual. It compels persons to contribute to the cost of a program which cannot be effectively carried out, and which will not improve the health of the people of this country. It appears that the bill fails to recognize the ultimate results which must flow from its enactment; that by its very terms it sets up conflicts which cannot be resolved without repudiating some of the promises which the bill makes.

IT IS NOT A TRUE INSURANCE PLAN

The proposed legislation is termed national health insurance but it is not actually insurance, because there is no sound actuarial basis to serve as the foundation of the program; nor is there any relationship between the proposed benefits and the ratio of premiums to be collected. Actually, even the proponents of the bill cannot give a clear estimate of the amount of funds which the proposed appropriation would provide in relation to the probable costs of offering the various health services; nor do they present a convincing forecast as to the probable immediate demand for various types of services proposed to be paid for in relation to the probable cost of these services.

In considering the so-called insurance aspects of the bill, it is necessary to examine the method by which a person would become eligible for benefits. In an ordinary policy of insurance he becomes eligible when the company accepts his contract and immediately upon the payment of his premium. Under the system proposed by the bill it must be assumed that the beneficiaries would contribute out of their wages. A formula is borrowed from the old-age and survivors insurance program to be used as the guide to eligibility. The bill provides that a person will be covered if he or she earns $150 per quarter in each of four of the first six quarters prior to the commencement of a benefit year; an alternative formula is provided for those who earn less than $150 a quarter. It is difficult to comprehend what constitutes the relationship between the earning of $150 per quarter and the right of a person contributing taxes to the fund to receive benefits. Under the proposed system a beginning wage earner would be taxed, and yet he might have to wait as long as 18 months, during all of which time he might be making tax contributions to the fund, before he would be eligible to receive the benefits. This certainly is not insurance and the formula just does not make sense, partcularly when other groups would be covered without the necessity for contributing anything to the fund.

Proponents of national compulsory health insurance claim that the Nation can solve its health problems by taking advantage of the insurance principle, which has been effective in many commercial and voluntary plans. There can be no question, philosophically, of the value of insurance to the individual and to the society if the insurance plan is actuarially sound and if it does not endanger the rights, privileges, and well-being of individuals and society. Insurance as a single entity is desirable. But insurance resulting in the adoption of dangerous social philosophies, excessive costs, and lowered standards of health service is undesirable.

These proposals cannot be carried out as sound insurance practice. Insurance is a method for providing protection against loss or a damaging event by spreading risks among a large number of potential claimants. The funds collected from the insured persons are used to pay insurance claims, administrative costs and, in the case of commercial agencies, dividends. In other words, a financially sound insurance plan is based on known actuarial experience; it is self-supporting through the collection of premiums, and it guarantees stipulated benefits.

The proposed federalized health care system must be financed, in part, by appropriations from the general revenue fund, in addition to pay-roll deductions or income taxes. The scheme would not be self-supporting, nor would it assure the provision of benefits to all persons covered under the plan. Thus, the system is not insurance, but actually is only a method for collecting additional taxes.

On numerous occasions supporters of compulsory health insurance have described the proposal as a "prepayment plant." The President used the term in his message to Congress. In a strict sense, prepayment is considered to mean payment in advance of the receipt of service. The question of whether a system of national compulsory health insurance can be classified as prepayment perhaps is only an academic one. Nevertheless, the fact remains that the federalized health plan must be subsidized by congressional appropriations and that the income-tax payments alone will not pay the billions of dollars in costs.

IT WILL LIMIT DENTAL HEALTH EDUCATION

The American Dental Association believes the proposed system of compulsory health insurance would not save more lives or reduce the prevalence of illness or more effectively prevent sickness or cure diseases. The death rates and prevalence of illness and physical defects, including dental disorders are lowered by preventive measures and by early and sound treatments. Experience has shown that in countries where the system exists the dental profession and its auxiliary aids are so busily engaged in restoring decayed and lost teeth there is no time for dental health education of the public and the stimulation of preventive measures. These aims can be reached without a system of compulsory health insurance; in fact, information from foreign countries indicates that dental health education and preventive measures for dental diseases are more effectively promoted in this country than in any other place in the world.

EVENTUALLY STATE MEDICINE WILL DEVELOP

The proposed legislation will eventually, if enacted, develop into a system of state medicine which means it will be absolutely controlled by the Government and its administrators. A third party who is directly responsible to the Government and only indirectly responsible to the patient is interposed between the patient and his dentist or physician.

Although a number of plans are proposed in the bill, which indicate that a practititioner could participate in the system on either a fee-for-service basis, under the penal system, or on a salary basis, nevertheless, considering the great size and population of our country and the necessary complexities of administration involved, it does not seem reasonable that any of these systems could be continued in effect very long. The fact that the bill provides for three different methods of payment to practitioners only serves to emphasize the increased administrative costs which would be incurred. In a relatively short time it would be necessary for the Government to abandon alternative methods of payment and to insist upon a salaried service and mass clinical service in health centers.

The Government would further intervene between the practitioner and the patient by its regulatory function under which it could prescribe the type of treatment or service which could be offered and the types and kind of medicine which could be administered. That this would occur is implicit from the bill itself, which permits the reduction of services where personnel or facilities or funds are limited.

When the limitation of services to be rendered comes about, the citizen would have to make private arrangements to obtain at his own cost such additional services as he might need, and this might be difficult to secure. In the final analysis the only hope for any degree of success in the operation of the federalized health plan proposed is regimentation. Regimentation of the people as to the service they will be given and regimentation of the profession as to the service they shall render is not the American way of life.

LIMITATION OF FREEDOM OF CHOICE

The bill proposes that each patient shall have a free choice of physician, dentist, medical group, hospital, and so forth, to render the services he needs or desires, providing, of course, that the entity so selected is participating in the plan, but it does not make clear to the public that this objective may be impossible of attainment within the necessary administrative limitations of the system. Obviously the choice of practitioner will be limited to the particular local health serviec area in which the beneficiary resides, and even then, within that area, whether operaetd on the panel, salary, or fee-for-service basis, there will be practical objection to permitting each person to select the practitioner of his choice. Obviously certain professional men and certain hospitals will be in greater demand than others, but the number of patients which each can handle is patently limited, thus the patient must seek for his first choice, and if not accepted there may have to be satisfied with any dentist who can accommodate him as a patient.

Again the bill sets forth that a practitioner shall be free to practice his profession in a locality of his own choosing and that he may be free to accept or reject any patient—subject to local law and professional ethics. But we have seen in Britain and undoubtedly it would happen in this country, that in certain areas which tend to attract more professional men in proportion to population than other areas, the Ministry of Health has refused to certify new practitioners for those overcrowded areas. This may be a practical solution to the problem of overcrowding, but it is not the American competitive way where the most skilled will survive professionally and the less skilled must get along as best they may. Under our present system of ethical competition in the health professions there is a tendency to stimulate the competitors to improve their skills in order that they may continue to be accepted by patients in the locality in which they choose to live. Where this freedom of location is denied by administrative fiat the element of professional competition from which individual economic security flows will be destroyed to the ultimate detriment of the health and welfare of the Nation.

DUPLICATION OF HEALTH SERVICE BENEFITS

The bills under consideration propose to offer a system of comprehensive health benefits to about 80 percent of the population of this country. If the bills were put into effect as contemplated nearly everyone would be entitled to obtain medical, dental, and hospital services. This, admittedly, will entail a great expenditure of money. Nevertheless, through oversight or otherwise, the bill fails to appeal, upon its effective date, the extremely costly medical, dental, and hospital services presently offered under veterans' laws to veterans for the so-called non-service-connected clauses. At the present time these non-service-connected benefits are justified on the basis of past service to the country and the immediate need of the veteran to whom they are rendered. However, if the veteran, like all of the other segments of the population, is entitled to receive comprehensive health care under these bills, then there can no longer be any justification for the non-service-connected medical benefits and in justice to the country these laws must be immediately repealed upon the taking effect of this act. Otherwise, the people of the Nation will be burdened with the expense of a costly duplication of benefits.

THE BILLS ARE NOT SPECIFIC

It is impossible to examine this bill carefully without being continually impressed with the fact that there is very little that is specific in the bill. Actually it amounts to little more than an appropriation coupled with a license to experiment along certain lines until such time as a firm base line can be determined. Yet if this is to be insurance why is this necessary? Congress has on at least two occasions passed laws which were specific and definite insurance policies containing generally within themselves the benefits to which the policyholders were entitled. I refer, of course, to the War Risk Insurance Act and to the National Service Life Insurance Act.

It has been a principle of government in this country since the time of the founding fathers that ours is a government of laws, not of men, and that to accomplish that end all statutes must be definite and specific. For this reason the courts have frequently held that broad, general language might constitute a delegation of legislative authority which is reserved to the Congress alone. Yet under the pending bill nothing definite will be known until such time as administrative regulations are promulgated, revised, rerevised, and possibly at some distant future date crystalized into such form that the Congress can adopt them as a statute. The American people are entitled to know at the time of enactment of a law its probable effect and its proposed cost. Neither of these can be ascertained under the pending bills.

A DENTAL HEALTH PROGRAM FOR THE UNITED STATES

The health professions have frequently been criticized for not presenting a positive approach to the solution of health problems of our people. However, this criticism is not justified in regard to the American Dental Association for it has long recognized that there are certain weaknesses in the distribution of our dental health services and has repeatedly appeared before the Congress to solicit its aid in the enactment of legislation which would in some degree help overcome these shortcomings. The association has on former appearances before congressional committees presented for the record a dental health program for the United States as advocated by the American Dental Association.

It is axiomatic that dental diseases affect some 95 percent of the population at one time or another during their life. The American Dental Association believes with regard to this problem that it is first important to intensify research which may lead to the prevention and control of dental diseases and thus reduce its incidence. Efforts to put this belief into practice have been made by the association, first, through the use of its own funds since 1913 for research problems; secondly, by encouraging the establishment of dental divisions in the departments of health of the various States; and, thirdly, through the sponsorship of the bill which became Public Law 755 of the Eightieth Congress, creating a National Institute of Dental Research.

I wish to thank this committee and Senator Murray and Senator Pepper and Senator Taft for their help in getting this through the Congress. All three of these Senators have very kindly appeared before the Appropriations Committee at a recent hearing to help us secure the appropriation in the Senate, and the Senate very kindly passed that appropriation, and we are hoping that the House will do likewise. So the American Dental Association believes this will be a very fine advance in trying to get at the cause of diseases which we hope to be able to control.

This authorized an appropriation for a building for such institute and an annual appropriation to carry out that research. It is only by extended and intensified research that more knowledge of the causes of dental disorders can be obtained.

The association believes that another step in the solution of the problem of dental diseases is an intensified dental health education program for children and adults. Unless people can be brought to realize the importance of early treatment of dental disorders, of proper dental hygiene, and of the need for starting dental examinations early in life, the problems of dental diseases will continue to increase rather than abate.

The association believes that dental care should be available to all, regardless of income or geographical location, and that programs developed for dental care should be based on the prevention and control of dental diseases. It has recommended the following program as an immediate planned action to accomplish this objective:

1. The prevention of dental diseases through the application of preventive technics as soon as they are demonstrated to be scientifically valid; the support of intensified dental research with adequate funds, personnel, and facilities.
2. The control of dental diseases by the expansion of community dental programs integrated in the general health program to make dental care and dental health education available to every child.
3. The provision of additional facilities and uniform standards for dental care by making dental services available in hospitals and health centers for in-patients and out-patients.
4. The recruitment of an annual enrollment of dental students equal to the capacity of all dental schools to increase the number of qualified dentists.
5. The adoption of measures to make dental practice in smaller cities and rural areas more attractive and more rewarding in order to procure a better distribution of dentists.
6. The employment of dental hygienists as auxiliary aids to the dentist; the provision of additional courses for those who desire to qualify for positions in public health departments and schools.

We have not attempted to discuss in detail titles I through VI of the bill. It is true that titles I, IV, V, and VI have a legitimate dental interest and might be worthy of comment by the association, but these titles are not offered as individual proposals to be examined on their own merit; instead, they are proposed as tools or aids to accomplish the purpose of title VII. Since the association is opposed in principle, for the reasons herein stated, to title VII, it does not feel that it is necessary to comment in detail upon the other titles of the bill.

SUMMARY

The dental profession is opposed to the philosophy of compulsory health-insurance legislation for the following reasons:

1. It is not good legislation for the Government because—
   - (*a*) It is too tremendous a task for the Government to administer.
   - (*b*) There is a misconception by the people of what the Government can and will deliver in health services.
   - (*c*) It will create an unwieldy Government bureau.
   - (*d*) It is an uncertain financial burden for the Government.
   - (*e*) It is contrary to democracy in Government, since it stifles private enterprise.
2. It is not good legislation for the people because—
   - (*a*) It promises more than it can deliver.

(*b*) It will cause deterioration of dental service and lower the level of health.

(*c*) The necessary administrative procedures will delay treatment.

(*d*) It will become a tax burden.

(*e*) It will eventually require regimentation, which it not the American way of life.

3. It is not good legislation for the profession because—

(a) It will destroy competition, inhibit ambition and industry.

(*b*) It will result in mediocrity in the profession.

(*c*) Excessive paper work will reduce the number of chairside hours which a dentists may devote to his patients.

The profession needs ethical competition, the private relation to and direct responsibility for the health of the patient, to attain its highest achievements.

CONCLUSION

The American Dental Association and the dental profession always have been and always will be interested in the health, and particularly the dental health, and welfare of the American people. It will conscientiously scrutinize any programs offered which relate to its legitimate field of interest, and it will comment fairly and without prejudice or selfish motives on such programs.

The dental profession opposes the enactment of the National Health Insurance and Public Health Act because it is not good health legislation for the people of the United States of America.

Senator MURRAY. Does that conclude your statement?

Dr. FLAGSTAD. Yes, sir, Senator.

Senator MURRAY. I think you have been here with us before many times.

Dr. FLAGSTAD. We are old friends together.

Senator MURRAY. I want to express my approval of your program of objectives. It sounds very much like you took it out of our bill, S. 1679, and I want to congratulate you.

Your association, of course, is on friendly relations and cooperates with the American Medical Association, does it not?

Dr. FLAGSTAD. Yes, sir.

Senator MURRAY. I notice in your statement here you say that the health professions have frequently been criticized for not presenting a positive approach to the solution of health problems of our people. However, this criticism is not justified in regard to the American Dental Association, for it has long recognized that there are certain weaknesses in the distribution of our dental health services and has repeatedly appeared before the Congress to solicit its aid in the enactment of legislation which would in some degree help overcome these shortcomings. You also say that the association has on former appearances been before the congressional committees and presented for the record a dental health program, and so forth.

I notice in another part of your statement you say that the successful dentistry that is practiced in this country has conributed tremendously to the health and welfare of the American people and has been one of the great factors in making America one of the healthiest nations in the world. That is true, is it not?

Dr. FLAGSTAD. That is true.

Senator MURRAY. You have not always been given credit for that. It seems to me the medical profession claims they are the sole ones who have made America such a great healthy nation. Do you agree with them on that?

Dr. FLAGSTAD. That the American Medical Association—I think the American Medical Association has done, indeed, a great deal to improve the health of the people, and we have, also.

Senator MURRAY. But do you think the dentists have contributed something to that?

Dr. FLAGSTAD. Yes; and I think even the Congress has contributed some to that.

Senator MURRAY. Yes; we have made vast contributions.

Dr. FLAGSTAD. That is right.

Senator MURRAY. Do you not think the contributions made by our Government with reference to hygienic conditions and various other activities have had a very important bearing in making the United States a very healthy nation?

Dr. FLAGSTAD. Yes; I believe the Government has a very important place in the health of the Nation, Senator, but there is a certain place where we differ as to how far you should go. Certainly, the Government is responsible for sanitation and many other things. Public health is necessary.

Senator MURRAY. Now, you recognize, of course, that there is a large proportion of our population that is unable to pay for the best modern medical care in this country, do you not?

Dr. FLAGSTAD. I would say there are certain portions of the population that are not able to pay.

Senator MURRAY. The American Medical Association at one time said people earning less than $3,000 a year would be unable to pay for a serious illness, and that statement was made some years ago, so that if you applied it to the present time, people earning less than $5,000 a year, which represents something like 80 percent of the population, would be unable to pay for modern medical care in any serious illness.

Dr. FLAGSTAD. I cannot vouch for the statistics of the American Medical Association, Senator, but I think I can say that there is a place where government needs to come in and help take care of them, and we have sponsored bills for that particular purpose, grants-in-aid, bills of different kinds. We are on record as favoring grants-in-aid of the Government in support of health programs.

The American Dental Association is for that.

Senator MURRAY. Of course, the testimony of the other witness here this morning points out that the income of the medical profession in this country is pretty high, that some of them earn as high as $186,000 a year. You do not think they need any assistance from the Government in paying them for their services, do you?

Dr. FLAGSTAD. I would hardly think so with that income.

Senator MURRAY. In the dental profession, do you not find also that there are a lot of people who cannot afford to pay for the best kind of American dentistry?

Dr. FLAGSTAD. They are being fairly well taken care of by other programs in the States and in the communities. We have programs in operation in practically every community and State to take care of these people; perhaps not to the extent we should like to, however.

Senator MURRAY. Notwithstanding that, there is a great part of our population that have not had any dentistry at all, and if we undertook at this present moment to give them complete dentistry the dental profession would not be able to do it; is that right?

Dr. FLAGSTAD. I think if we were to rehabilitate all the mouths and put them in perfect condition, all within a very short time, I think it would be quite a task—impossible. However, many of these people who have not had dental service—it is not due to the fact particularly that it is not available, but because they have not taken advantage of the availability of the service.

Senator MURRAY. It is due to the fact that they did not receive the care they should have in early life, is it not?

Dr. FLAGSTAD. That is true, and we are in favor of a program of concentration on children.

Senator MURRAY. And the Congress is in sympathy with that program and intends to go forward in the establishment of a program that would have a tremendous effect on the future dental health as well as the physical health of the people of this country.

Dr. FLAGSTAD. That is right.

Senator MURRAY. Do you have any questions?

Senator DONNELL. I have a few questions.

Doctor, do you know very many dentists or doctors of medicine or surgery who make $186,000 a year or near that?

Dr. FLAGSTAD. I am not familiar with the medical income. I am somewhat familiar with the dental income, and I know of nobody who receives anywhere near that amount of money.

Senator DONNELL. You mentioned being in favor of grants-in-aid.

Dr. FLAGSTAD. Yes, sir.

Senator DONNELL. Are you familiar, generally speaking, with the Taft bill, S. 1581?

Dr. FLAGSTAD. Yes, sir.

Senator DONNELL. Have you studied that bill, Doctor?

Dr. FLAGSTAD. We have not passed upon it. We have studied it some.

Senator DONNELL. Have you personally studied the bill?

Dr. FLAGSTAD. Yes; I have looked it over.

Senator DONNELL. Would you tell us, please, just in a nutshell whether or not you favor that bill or whether you are opposed to it?

Dr. FLAGSTAD. We favor the philosophy of the bill and the grant-in-aid system, and the taking care of those who are unable to pay and those who are only able to pay in part, and the subsidy of States and local communities by grants-in-aid to set up a health program.

There is another part of the bill there on which no policy has been set and which we will not pass judgment on at this time.

Senator DONNELL. Which is that?

Dr. FLAGSTAD. The same as title I of S. 1679, the matter of subsidy and grants to dental schools, and so forth.

Senator DONNELL. But this matter of grants-in-aid and the matter of assisting States by grants-in-aid to bring about treatment for persons who are unable to pay for the treatment themselves, either in whole or in part, that meets with your approval?

Dr. FLAGSTAD. That has been passed by the house of delegates of the American Dental Association. They are in favor of grants-in-aid as a system to support dental-health programs in communities and States under the complete supervision of the State and the community, not the Federal Government, and they also favor service to those who are unable to pay and those who can only pay in part.

Senator DONNELL. And those policies to which you have just referred, to which the house of delegates has addressed itself, are among the fundamental policies set forth in S. 1581?

Dr. FLAGSTAD. That is right, and there are some details in the bill which our testimony of last year covers, which I think we are not in accord with.

Senator DONNELL. That is all, Mr. Chairman.

Senator MURRAY. Thank you, Doctor.

I have a request to call Dr. Bauer at this time so that we may complete his testimony this morning, and also Dr. Sensenich.

Dr. SENSENICH. Mr. Chairman, we appreciate the opportunity to come before your committee, and we feel we have a public responsibility in so doing, just as the committee, no doubt, feels it has a responsibility in hearing us.

There are four of us here this morning, but we are going to limit the statement to two and will do the best we can to conserve your time because we know you have much to do.

Senator MURRAY. Thank you very much.

Dr. SENSENICH. I would like to introduce the witnesses. Dr. Harvey Stone, who is professor of surgery at Johns Hopkins and also a member of the council on medical education and hospitals of the AMA. I might mention that we are all practicing physicians.

Next is Dr. Louis Bauer, who will give a statement in a moment. Dr. Bauer is chairman of the executive committee of the board of the American Medical Association. He specializes in internal medicine and is from Hempstead, N. Y.

Next is Dr. Lowell S. Goin of Los Angeles, Calif., who specializes in radiology and is past president of the California State Medical Association and the president of the California Physicians Service and a member of the house of delegates of the American Medical Association.

I am making these introductions now so we could go right along with our statements. Dr. Bauer, by the way, is a past president of the New York State Association and, I think, every other association in New York that I know anything about. Dr. Bauer will make his statement first and then Dr. Goin, and we will all be available for questions if we can be of any help.

Senator MURRAY. Thank you, sir. We are all becoming well acquainted with these doctors you have introduced. I have met them before and am very glad to have them here.

Dr. SENSENICH. We have had some very interesting meetings from time to time. I would like to say this off the record.

(Discussion off the record.)

Senator MURRAY. You may proceed, Dr. Bauer.

STATEMENT OF DR. LOUIS H. BAUER, HEMPSTEAD, N. Y., ON BEHALF OF THE AMERICAN MEDICAL ASSOCIATION, ACCOMPANIED BY DR. ROSCOE SENSENICH, SOUTH BEND, IND.

Dr. BAUER. Mr. Chairman and members of the committee, my name is Dr. Louis H. Bauer. I am a physician and appear as a member of the board of trustees of the American Medical Association which had a membership as of May 1, 1949, of 142,882 physicans. My home is in Rockville Center, N. Y., and my office is in Hempstead, N. Y.

It is my understanding that today detailed consideration will not be given to the proposals contained in the four bills on which hearings are being held, S. 1106, introduced by Senator Lodge, to provide assistance to the States in furnishing certain medical aid to needy and other individuals; S. 1456, introduced by Senator Hill, for himself and Senators O'Conor, Withers, Aiken, and Morse, to authorize grants to enable the States to survey, coordinate, supplement, and strengthen their existing health resources so that hospital and medical care may be obtained by all persons; S. 1581, introduced by Senator Taft, for himself and Senators Smith of New Jersey and Donnell to enact a National Health Act of 1949; and S. 1679, introduced by Senator Thomas of Utah for himself and Senators Murray, Wagner, Pepper, Chavez, Taylor, McGrath, and Humphrey, to provide a program of national health insurance and public health and to assist in increasing the number of adequately trained professional and other health personnel.

Acting on this information, the statement that I will present to the committee will be general in character, but the association does desire the opportunity to submit at a later date comments on some of the suggestions contained in these bills. Representatives of the association have appeared a number of times before your committee in connection with previous bills which have suggested the enactment of a compulsory sickness-insurance program under Federal supervision.

We would like to reiterate some of the viewpoints that we have previously stated with respect to this particular proposal and would like to offer additional comments on the Lodge bill, the Taft bill, and the Hill bill and on some of the other titles contained in S. 1679 which is, I believe, referred to as the administration bill.

There is little disagreement as to the desirability of the widest possible distribution and availability of the best quality of medical care. The differences of opinion arise as to the best way to attain this objective. It is the belief of the medical profession generally that the primary responsibility for the health of individual citizens rests on the individual citizen and on his immediate family. Where the requirements of a particular situation exceed the ability of the individual or his family to meet them, the local community, by the American tradition, comes to his aid. Should the resources of the local community prove inadequate to deal with the volume of demand for assistance in the health field, the problem then becomes the responsibility of the State.

It is only when the State in its turn is unable to cope with these demands that there should be recourse to Federal assistance. We believe that this procedure is in accordance with sound American tradition, with the intent of our political principles, and with the maintenance of self-reliance and independence of each of these levels of relationship, from the citizen to the National Government.

It follows that the local community or the State should make provision for the supplying of medical care to those of its citizens who find themselves financially unable to procure needed services. It is customary to speak of such economic groups as the indigent or medically indigent. It is believed that a simple system can be set up by which those falling into these groups may seek the services of any reputable physician and that such physician may be recompensed from public funds in accordance with an established fee schedule.

Perhaps it would be necessary in order to prevent abuse that a welfare department or some other investigating agency of the political unit should certify to the propriety of covering the specific case under the provisions of the system. Such a system is not merely a theoretical proposal. It is already in practical operation and is proving generally satisfactory.

There may, of course, be other types of organization and wide diversity in detail in the methods adopted to meet the health problem at the local and State level. The point of importance is that the responsibility lies here and should be recognized and so far as possible met at the local and State level. Only when these political subdivisions have made full effort and fall short of accomplishment should recourse be had to Federal assistance.

Under such circumstances it may become incumbent on the Federal Government to support the State effort. This support may take the form of supplying advice, experience, expert personnel on a loan basis, or financial aid. Before financial aid is granted, it should be established that the individual State has made genuine efforts to solve its own problems, that its health program is soundly conceived and efficiently operated, and that only lack of funds as evidenced by the general economic condition of the State is the reason for the need of Federal financial assistance. Nothing in the relations set forth, however, should imply that the Federal Government should assume the right to dictate a single system of medical care for all States, nor to attempt to control the appointment of personnel in the State plans nor otherwise to exercise improper interference. There should perhaps be a recognized percentage limit, as relative to the total cost of a State plan, beyond which Federal financial aid could not be extended.

It will be seen that this conception of the relation of the Federal Government to the provision of medical care to the least favored economic groups is that of a stand-by support of the State programs. It would place primary responsibility and initiative on the State and local governmental divisions. It would prevent dominance of the local authorities from Washington. It would limit interference in State plans to the approval of their adequacy and efficiency. It would make the need for financial assistance and the amount of such assistance dependent on the economic status of each particular State.

From what I have said, it will be obvious that any plan for Federal participation in the handling of the problems of medical care that lodges primary initiative and control in Washington, that contains uniform and compulsory features on a Nation-wide basis, and that lays a direct Federal tax on citizens generally to finance the program is unacceptable in principle. Such plans concentrate further power in the Central Government, they absorb in Washington functions much better retained at the local level, and they greatly enhance the over-all cost of providing health services. Most important of all, they would lead to a widespread and serious deterioration of the quality of medical care.

The provision of medical services to the indigent is not all of the problem that faces us in the matter of general adequate medical care. There is a large group, above the level of medical indigents, who yet find the professional service cost of a serious illness a grave financial problem. These people need security against such calamities, and it is the accepted idea that the insurance principle is the answer to the problem, but it should be voluntary insurance. There is no justifiable reason for assuming that these people are minors or incompetents and compelling them by Federal law to participate in a Nation-wide system of prepayment for so-called health insurance. Leaving aside any questions as to the Government's being able at this time to deliver the services promised and paid for under such a scheme, it constitutes an extreme example of compulsory paternalism, wrong in principle, impossible of practical operation, and contrary to our established ways and habits of life and political principles.

This is not meant to imply that effort is not needed to stimulate the widespread development of voluntary prepayment plans for insurance against the professional costs of serious illness. Such plans already have an extensive existence and are spreading rapidly. They deserve the wholehearted support of all who are honestly interested in this problem. Such plans are actuarially sound, are well managed, and are backed by a medical profession ready to accept some financial sacrifices, if necessary, for a large public good. There is no reason, after the experimental period has passed, why such plans should not be self-supporting. The only question of governmental aid, either State or Federal, might concern certain marginal financial groups and certain short initial development periods.

The council on medical service of the association, created by the house of delegates in 1943, has conducted a continuing study of proposed programs pertaining to the economic, social, or other similar aspects of medical care, has suggested improvements in such programs, and has made available all information that it has been able to assmble. The council has taken the initiative in assisting in the promotion of voluntary prepayment programs. The term "assisting" is used advisedly because much of the actual promotion must be done at the State and local levels, by the plans themselves, by the medical societies, and by physicians.

I would like to leave with the committee a copy of a brochure prepared by the council, revised as of 1948, which contains detailed information with respect to the various medical care voluntary programs that are in existence at the present time in some 43 States. If, during the course of these hearings, members of the committee wish further testimony with respect to the plans themselves, the association will be only too glad to make that information available. Suffice it to say here that approximately 57,000,000 people have hospitalization coverage and approximately 30,000,000 have surgical coverage, both as a result of voluntary action on their part.

The association has now completed over 100 years of organized existence. During these years it has developed an ever-expanding program with a view to charting a safe and sure road toward the advancement of the Nation's health. It has directed continuing study and experiment to improve methods of undergraduate education in medicine, the organization of opportunities for postgraduate study, and the creation of facilities for the provision of the best medical care, including service to the indigent and those of low income.

The direction of these efforts throughout the whole field of study and the improvement of standards and methods have been characterized by close contact and cooperation with the health activities of governmental agencies, Federal, State, and local; educational and research institutions, voluntary groups; and philanthropic health agencies. It has observed closely the standards and methods of distribution of medical care of other nations and has had the benefit of the experience and advice of unselfish investigators trained in the direction of health activities throughout the world.

These broad considerations of the problem of the best possible health for all the people has led the association to prepare a basic outline for continuing development and action. This is known as the Program of the American Medical Association for the Advancement of Medicine and Public Health. This program embraces 12 major points or planks, some of which have been advocated by the association for many, many years. This program follows:

A FEDERAL DEPARTMENT OF HEALTH

1. Creation of a Federal Department of Health of Cabinet status with a secretary who is a doctor of medicine, and the coordination and integration of all Federal health activities under this department except for the military activities of the medical services of the armed forces.

MEDICAL RESEARCH

2. Promotion of medical research through a national science foundation with grants to private institutions which have facilities and personnel sufficient to carry on qualified research.

VOLUNTARY INSURANCE

3. Further development and wider coverage by voluntary hospital and medical care plans to meet the costs of illness, with extension as rapidly as possible into rural areas. Aid through the States to the indigent and medically indigent by the utilization of voluntary hospital and medical care plans with local administration and local determination of needs.

MEDICAL CARE AUTHORITY WITH CONSUMER REPRESENTATION

4. Establishment in each State of a medical care authority to receive and administer funds with proper representation of medical and consumer interest.

NEW FACILITIES

5. Encouragement of prompt development of diagnostic facilities, health centers, and hospital services, locally originated, for rural and other areas in which the need can be shown and with local administration and control as provided by the National Hospital Survey and Construction Act or by suitable private agencies.

PUBLIC HEALTH

6. Establishment of local public health units and services and incorporation in health centers and local public-health units of such

services as communicable disease control, vital statistics, environmental sanitation, control of venereal diseases, maternal and child hygiene, and public health laboratory services. Remuneration of health officials commensurate with their responsibility.

MENTAL HYGIENE

7. The development of a program of mental hygiene with aid to mental hygiene clinics in suitable areas.

HEALTH EDUCATION

8. Health education programs administered through suitable State and local health and medical agencies to inform the people of the available facilities and of their own responsibilities in health care.

CHRONIC DISEASES AND THE AGED

9. Provision of facilities for care and rehabilitation of the aged and those with chronic diseases and various other groups not covered by existing proposals.

VETERANS' MEDICAL CARE

10. Maintenance of existing high standards of medical care for veterans, including extension of facilities where the need can be shown and, where practicable, care of the veteran in his own community by a physician of his own choice.

INDUSTRIAL MEDICINE

11. Greater emphasis on the program of industrial medicine, with increased safeguards against industrial hazards and prevention of accidents occurring on the highway, home, and on the farm.

MEDICAL EDUCATION AND PERSONNEL

12. Adequate support with funds free from political control, domination, and regulation of the medical, dental, and nursing schools and other institutions necessary for the training of specialized personnel required in the provision and distribution of medical care.

Is the health of the American people in such a low state as to necessitate revolutionary remedies, or proposed remedies, to be made available by the Federal Government as contemplated by the legislation pending before your committee? What actually is the record of our health progress under the system that prevails in the United States?

In 1900, 1,000 babies—white and nonwhite—were destined to live in the aggregate 49,000 years. One thousand babies born in 1949 are destined to live an aggregate of 68,000 years. Even among nonwhites, whose living conditions and health standards are admittedly lower than those of the white population, the years to be lived increased from 34,000 to 61,000. In terms of life expectancy at birth, the average for the whole United States population has risen from 49 years in 1900 to 68 years in 1949. Health progress certainly must have been enjoyed by all segments of our population in order to achieve this progress.

While the population of the United States has doubled since the turn of the century, from 75,000,000 to 150,000,000, the number of people over 64 years of age has quadrupled 3,000,000 to 12,000,000. The increase in the average age of the population caused by the increased number of old people is reflected in the fact that while in 1900 only 4 out of 12 funerals were for persons over 50 years of age, today, 9 out of every 12 funerals are for persons who have lived half a century or more. Health progress, in other words, has raised the average age at death. The older half of the people dying in 1900 had lived 30 years or more. At the present time half of the people dying have lived at least 66 years. Medical progress, therefore, has succeeded in allowing more and more people to live on to higher ages.

Maternal mortality rates are another example of progress. In 1933, the United States ranked eleventh among all nations in maternal mortality, with 6.2 deaths per 1,000 live births. In 1947, the rate had declined to 1.3 deaths per 1,000 live births (see the Journal of the American Medical Association, vol. 140. No. 1, p. 113, May 7, 1949). Unless Sweden (and perhaps Denmark, England, and the Netherlands) had a lower rate in 1947 (and data for 1943 are the latest available in these countries) the United States probably ranked close to the lowest record in maternal mortality in all nations in 1947. It is of equal importance that the State having the worst record in 1947, 2.6 deaths per 1,000 live births, had a maternal mortality rate of less than two-thirds of the rate of the best State in 1933, 4.3 per 1,000. Thus health progress has, at least by these indicia, been general throughout the United States.

It is acknowledged, I believe, by the advocates of compulsory sickness insurance that our health progress has indeed been remarkable but it is claimed that, among other things, 325,000 deaths from enumerated causes could be prevented each year and it is inferred that this prevention can be accomplished only by compulsory sickness insurance under Federal direction. Some proponents of compulsory health insurance propose to reduce the number of deaths from communicable diseases annually by 120,000, from cancer and heart disease by 115,000, from fatal accidents by 40,000, from conditions relating to infancy and maternity by 30,000 and from other causes by 20,000. With a continually increasing population the number of deaths must increase. The rising number of deaths from heart disease and cancer is actually a result of medical progress. Modern medical science has saved men from death from pneumonia at 35, but these men will eventually die of heart disease, cancer, or some other cause. The physician can change only the cause of and age at death—he can never absolutely prevent death.

Maternal mortality has already been referred to and infant mortality shows similar progress. In 1920 we ranked ninth among the leading nations of the world in infant mortality counting our nonwhite population. And it should be noted that many of the other countries used in this comparison have a relatively small nonwhite population. Thirty years later, in 1950, we will have progressed to third or fourth rank.

What about deaths from communicable diseases and accidents? Deaths from communicable diseases have showed a consistent decline but such deaths are fostered not so much by the lack of availability of medical care as by poor and overcrowded housing, lack of strict enforcement of sanitation laws, and inadequate education of the public in general health matters. Deaths from communicable diseases, therefore, are not solely a medical problem.

Accidental deaths are not primarily a medical problem, either, but today fatal accidents cut off more years from the working lifetimes—age 20 to 65—of the American people than the condition that causes the most deaths, heart disease. The average age at death from heart disease is 67 years while the average at death from accident is 46 years. Medical care is almost always available to badly injured persons and most deaths occur soon after the accident. The task of preventing accidents lies with the safety directors and educators and not with the medical profession solely.

Much has been said about the alleged shortage of physicians. Those who contend that there is a shortage base their contention on the fact that the 12 States that have the largest number of physicians per 100,000 population—150 physicians—represent the desirable norm and and that all States should measure up to this norm. On the basis of this mechanistic formula, it is forecast that in 1960 there will be a shortage of some 42,000 physicians. It is predicted, by those who advance these contentions, that at the present rates of production of physicians there will be 212,000 active physicians by 1960 and to meet the standard percentage obtaining in the 12 best States, there will be needed by that year 254,000 physicians.

The formula that forms the basis of these estimates assumes that the same percentage of physicians per 100,000 population is desirable and necessary in every State and leaves out of consideration that in the so-called 12 best States, a large number of interns and residents in teaching centers may unduly increase the physician population of the 12 best States. Even if 42,000 more physicians could be trained by 1960, and assuming that such an increase is necessary, there could be no assurance that the excess number of physicians would locate in States that do not measure up to the average physician population obtaining in the 12 best States. It is true that although the construction of hospital facilities and diagnostic clinics authorized by the Federal Hospital Survey and Construction Act may make the less remote area attractive to more physicians, there are many more factors that influence the location of physicians than hospital and diagnostic facilities, such as schools, and opportunities to maintain professional contacts so necessary in the practice of medicine.

Furthermore, since 1940 the population has increased 13 percent and the number of physicians has increased 15 percent, so the relative number of physicians to the population has increased rather than decreased. The number of physicians practicing in a given area does not necessarily represent the supply of medical care available. Where once the physician carried on alone, much of the routine work today is assumed by technical assistants, nurses, and research workers. This situation automatically enables a physician to do a greater volume of practice and the conveniences of transportation enables him to cover a much wider territory.

It has been said, too, that 80 percent of the American people are unable to afford all of the medical care they need. This statement by implication assumes that the only type of economic goods or services purchased by the American people is medical care and overlooks the fact that the purchase of medical care is a matter of free choice for the majority of the people.

The fact is that we live in a free society where the consumers are the dictators so far as the commodities that they choose to purchase and the commodities that they do not purchase are concerned. In the past, the decision of the consumers has been to spend 96 percent of their income for items other than medical care. They have decided that they can afford 1½ times as much for alcoholic beverages as for medical care and another 1½ times as much for recreation.

Senator MURRAY. May I interrupt?

Dr. BAUER. Yes.

Senator MURRAY. You say that in the past the decision of the consumers has been to spend 96 percent of their income for items other than medical care. Of course, many people have gotten into the habit of feeling that medical care is something that is not necessary and, therefore, they do not want to spend any money on it. If we could all be healthy and free from disease, we would not have to waste our money on medical care.

Dr. BAUER. I think it is true, Senator, that people have not become used to budgeting for medical care as they budget for many other things.

Senator MURRAY. That is true, but a lot of people look on medical care as an unnecessary luxury that they should not be bothered with.

Dr. BAUER. Yes, sir. They have decided that they can afford twice as much for tobacco as for the services of physicians. They have decided they can can afford considerably more for personal care than for doctors' care. They have decided they can afford about as much for jewelry and repairs of watches and clocks as for physicians.

These were not the decisions of the medical profession nor of any other group offering medical or allied services, but they were the decisions of 147,000,000 people. If we must be frank, the American people spent only 4 percent of their income on medical care, not because they did not have more to spend, but because they preferred to spend 96 percent for other purposes.

I shall not undertake to explore in detail the cost of a comprehensive system of medical care as contemplated by the pending legislation. I believe that it is anticipated that initially the system will be financed by pay roll deductions plus appropriations from the general funds. Estimates by competent actuaries place the cost from $10,000,000,000 to $15,000,000,000 annually. The assumption has been made that there is a financial barrier between a very large part of the public and the medical service they need, but this barrier in the main relates to ability to pay for large and unexpected expenditures incurred for medical needs. This is a situation that is being overcome progressively by the rapid development of private health insurance plans. Although the provisions of these insurance policies vary greatly, in general they do permit the family to budget the major costs of medical care.

It is true that all types of medical care coverage are not available throughout the United States and that some are available only to members of employed groups, but progress is being made toward complete coverage. The cost of such coverage varies, of course, with the benefits made available. A family may, for instance, purchase a typical Blue Cross-Blue Shield membership which will pay the bulk of hospital and in hospital medical bills for 20 cents a day, the price of a package of cigarettes or a bottle of beer a day.

In return for the money spent on medical care, the American people have received a truly phenomenal measure of health. During the 1940's the medical profession delivered an extraordinarily high quality and great quantity of medical care at an extremely low cost. While the cost-of-living index of the United States Bureau of Labor Statistics in 1948 was 171.2, the index of medical care prices was 141. In other words, the combined average prices charged by physicians, dentists, and by hospitals has not risen as fast as the cost of living.

It is abundantly clear that the cost of medical care has risen during the 1940's in terms of dollars, but the percentage of the consumer budget taken by medical care has not risen. Meanwhile life expectancy at birth and at every age has risen. This triumph of medical economic, steadily increasing life expectancy at the same percentage cost of the consumer budget, may well be the major contribution of medicine in the 1940's. For 4 years of life expectancy at birth gained in the last decade alone mean many millions of dollars earned and the chance of a good life for many more people than ever before.

Yet in the midst of all this health progress, it must be remembered that medical care can never be wholly adequate as long as pain comes too often and death too soon.

That is my statement. I would like, if I may, to comment on something said this morning about the number of medical schools and increased number of physicians.

Senator Murray. You may.

Dr. Bauer. The gentleman who was testifying said that he might be ignorant on it, and I am afraid he was.

The American Medical Association can inform you that there are nine new medical schools within the last few years. There is the University of Alabama, which has been increased from a two to a four-year school; the University of Utah, from two to four; the University of North Carolina, from two to four; and then new schools: The University of Washington, the University of California at Los Angeles, and the Southwestern Medical School at Dallas, Tex., and there are others in the making.

Senator Murray. They have increased their course from a 2-year course to a 4-year course?

Dr. Bauer. Yes; some of these schools at the time did not have the facilities for a 4-year course. They gave the first 2 years and then their students had to be transferred to another school. Now, they have been made 4-year schools, so not only will you have the enrollment of those schools, but the vacancies that would ordinarily be filled by these transfer students can now be filled by other schools in an original enrollment. We are getting more doctors all the time.

At the present time we are graduating between 5,500 and 6,000 a year. I think the average rate of death among the doctors is somewhere about 3,500 a year, and the doctors are increasing at a faster rate than the population is increasing.

I think it is a question of where are you going to set the limit on how many doctors you need.

Senator Murray. You do not think the problem of medical education is a serious problem?

Dr. Bauer. No, sir; I think it is being taken care of. Of course, these new schools, you have not got the results from them yet because they have just been started, and it takes 4 years to start getting results, even longer than that, but the problem of producing more doctors, I think, is being taken care of satisfactorily because we are turning out more now than we ever have, with prospects of still more.

We have now, as was said this morning, 1 doctor per every 740 individuals in the United States. Unfortunately, that is not true all over the country. It will vary from 1 to 450 in New York City to one to fifteen or eighteen hundred in some of the rural areas; so that problem is how to get a better distribution of doctors; it is more that than it is how to get more doctors.

Senator Murray. The general impression in the country is that there is a very great deficiency in the number of doctors that we should have, and it has been contended by some of those who criticize the administration's program that if it was put into effect, there would not be enough doctors in the country to begin to carry it out and, therefore, that we should begin to greatly expand medical education and increase the number of doctors in the country.

As the population grows and our economy expands, it will become more necessary than ever to have more people engaged in the services, and the medical service is a place where a lot of people, a lot of young people are looking to now to enter.

Dr. Bauer. I do not mean to infer that we do not need more doctors, I think we do need more, but I say we are getting them steadily and we are going to have still more because there are still other schools in the process of establishment which will still further increase it.

Also you must remember that illness is diminishing, the actual morbidity rate in many diseases is fast disappearing, so fewer people get sick, and the diseases which disabled them for a long period of time are now disabling them for a short period of time.

For example, typhoid fever, when I was an intern we had whole wards with typhoid fever patients. Now, when a typhoid case comes in the hospital, doctors flock in from miles around to see the case, because they have never seen one.

Pneumonia used to incapacitate a man for 2 or 3 weeks. Now pneumonia has almost arrived at the status of a minor disease. The death rate is about 2 percent now, and they are disabled only a few days.

Illness is decreasing. During the war we had 50 percent of our doctors in the military services and yet the health of the people went along pretty well.

Senator Murray. Is it not true that in some diseases we are finding an expansion of the number of people who are infected by those diseases and that the diseases are becoming more deadly? For instance, take tuberculosis. I noticed an article in the paper that there is a serious situation developing in regard to that disease.

Dr. Bauer. In tuberculosis, in this country the tuberculosis rate has been gradually declining, the death rate. In certain European countries since the war it has been steadily mounting, but there the tuberculosis has reached the stage where people are even optimistic enough to believe tuberculosis can be wiped off the map as typhoid fever has been.

Senator Murray. That is true, but I read in the paper that tuberculosis cases they are getting recently are very much more serious than the ones they had in the past.

Dr. BAUER. Well, of course, the minute you eliminate any disease to a certain extent, when you develop cases, they are apt to be serious.

Senator MURRAY. That may be an indication that the disease is being taken care of.

Dr. BAUER. Yes. You take in the South Pacific, for example, I remember years ago I was on an Army transport. They would not let us land because we had a case of measles on board. Measles was considered a greater scourge than smallpox because the population was not used to it.

Sentor MURRAY. Are you finished, doctor?

Dr. BAUER. Yes, sir.

Senator MURRAY. Do you have any questions, Senator?

Senator DONNELL. Doctor, on page 4 of your statement you refer to the view that the plans which you mention, namely, the plan for Federal participation, the plan that contains uniform features, and so forth, would lead to a widespread and serious deterioration of the quality of medical care.

Do you think that opinion is generally shared by the members of the medical profession, that that result would follow?

Dr. BAUER. Yes, sir; I do. I think it has been more or less evidenced in other nations that you get a stereotyped type of medical care.

Senator DONNELL. Would you mind telling us why you get such a stereotyped type of medical care and what the fundamental reason is for the conclusion at which you arrive that these plans would lead to serious deterioration of the quality of medical care?

Dr. BAUER. I think there is more than one reason. First of all, I think you eliminate the factor of competition entirely, because a poor doctor can do just as well as a good one. In fact, it has been stated many times that compulsory health insurance is a great leveler. It does not bring the poor doctor up to the level of the good one, but it drags the good one down to the level of the poor doctor.

At the present time, if a doctor is called by a patient, he knows he has to deliver the goods or else the patient will get somebody else; whereas, under a controlled system of any character, a doctor does not care very much because he gets paid whether he delivers good medical care or whether he does not.

This is not an incentive to the right type of man to go into medicine, and it results, I think, in a deterioration in the type of individual who goes into medicine.

Then, doctors are overloaded with trivial complaints because of the system's being so-called free, and they go to the doctor for conditions which they ordinarily would not go to him for if they had to pay for it. Under the system, for example, the ordinary individual has a casual headache, he will buy a bottle of aspirin. Under the other system he would not because by getting a prescription he would not have to pay for the aspirin. That is an illustration.

The doctors are apt to be overloaded with trivial complaints, so they do not have the time to devote to people who are really ill. Many of the systems, of course, we know what we have seen abroad, and I have been in many of the countries in Europe.

Senator DONNELL. You say you have been personally?

Dr. BAUER. I have been in many of the countries of Europe, and the doctor has to see a great many patients in the course of a day to make a living or to get through his list, and he cannot devote the time to them which he should.

Of course, there is a lot of certificate work, certificate writing involved with these things. How this administration bill would work out, I do not know, but I do not see how a great deal of paper work can be avoided. It seems to depend to a great deal on the system as to the amount of paper work, but if it is on a fee-for-service basis, there would be a tremendous amount of paper work.

Senator DONNELL. Have you seen the regulations in force in England as of a year or so ago?

Dr. BAUER. I think the volume containing the laws is something like 1,300 pages and the volume the doctors were supposed to use every day was somewhere around 600 pages. That is from memory.

Senator DONNELL. What countries have you personally visited in Europe?

Dr. BAUER. England, France, Switzerland, Spain, and before the war I was in Germany and in Italy.

Senator DONNELL. In which of those countries have you made observations with respect to the operation of health insurance plans of the type that you described?

Dr. BAUER. In all of them to a certain extent, except Italy. I did not make any there.

Senator DONNELL. And your net conclusion is that there has been or has not been a deterioration in the quality of medical care in the countries in which you have visited?

Dr. BAUER. I do not know that I could answer that question by saying there has been a deterioration because I was not familiar with what it was before they got it, but I can say that the level of medical care is distinctly lower than it is in the United States under our system.

Senator MURRAY. When did you visit England, Doctor?

Dr. BAUER. I have been in England three times in the last year and a half.

Senator MURRAY. When was your last visit?

Mr. BAUER. My last visit was last September. However, at that time I was there for such a short period I did not have an opportunity to make any personal investigation of the new health act.

Senator MURRAY. And the present health service program had just recently been put in effect?

Dr. BAUER. Just 2 months previous.

Senator MURRAY. It would have been impossible for you to make——

Dr. BAUER. Any personal observation on that, that is correct.

Senator DONNELL. But you did observe the operation of the health act immediately preceding the new act?

Dr. BAUER. Yes, sir.

Senator DONNELL. The point has been made with respect to S. 1581 that inasmuch as it confines its grants-in-aid to the States for the purpose of aiding those who are in need of medical assistance and cannot provide it for themselves, at least in full, that a certain humiliation would attach to the recipients who would avail themselves of the service.

What is your judgment in regard to that point?

Dr. Bauer. I cannot see that myself. I have read a lot about the means test. It seems every one of us has to go through a means test. Every time you put in an income tax you are going through a means test. I cannot see anything humiliating about it.

Senator Murray. I would like to see a law abandoning the income tax.

Dr. Bauer. I would be in favor of it.

Senator Murray. We would not have so many headaches.

Senator Donnell. Is it your judgment that S. 1581 is properly to be condemned on the theory that the administration of aid to persons who need it, as distinguished from those who do not, would be humiliating?

Dr. Bauer. The so-called Taft bill?

Senator Donnell. Yes, sir.

Dr. Bauer. No, sir; I do not think it is to be condemned on that at all.

Senator Donnell. That is all, Mr. Chairman.

Senator Murray. Doctor, I would like to call your attention to some analysis of the 12 points that you have presented here.

Dr. Bauer. Yes, sir.

Senator Murray. Dr. Channing Frothingham, chairman of the Committee for the Nation's Health, a member of the AMA, and twice president of the Massachusetts Medical Society, has this criticism to make. He says:

> Some of the AMA's 12 points are mere pious platitudes calling for expansion of present Government activities such as health education and industrial medicine (No. 8 and No. 11). Some already are incorporated in law such as Government aid for construction of hospitals (No. 5) and a program for mental hygiene (No. 7). Others are included in legislation now pending before Congress, such as creation of a national science foundation (No. 2); State medical care authorities (No. 4); aid for local public-health services (No. 6); and expansion of medical, dental, and nursing education (No. 12). The AMA has initiated none of these advances.
>
> The AMA's first proposal—for creation of a Federal Department of Health with cabinet status—was rejected by the Eightieth Congress and more recently turned down by the Hoover Commission and the House Expenditures Committee after hearing the AMA spokesman. The proposal for putting a doctor in the Cabinet is as out of step with American tradition as for the Army to demand a general in the Cabinet. The American people trust their doctors to deal with disease just as they trust their generals to win battles, but they are firmly set against permitting these specialists to determine broad public policy.
>
> The only hint of anything new in the AMA program is in point 9, the proposal for facilities for the care and rehabilitation of the aged and those with chronic disease. If really carried out, this would cost billions of dollars of the taxpayers' money.
>
> The AMA has fought national health insurance, the cost of which would be borne by the beneficiaries and their employers, as too expensive. It has made no estimate of the cost of its own point 9, or its proposal to subsidize AMA-controlled voluntary-insurance plans. We challenge the American Medical Association to make such estimates. They might disclose that organized medicine is more concerned over who controls the finances of medical care than how much it costs the people.

Do you have any comment to make on that?

Dr. Bauer. Yes, sir; I have several comments. Dr. Frothingham is not president of the Massachusetts Medical Society. He was but is not at the present time.

Senator Murray. I said he had been twice president of the Massachusetts Medical Society and a member of the AMA.

Dr. BAUER. A great many of these things, I agree, are in the process of accomplishment, but in presenting any program the whole field should be covered.

Senator MURRAY. Most of the things he refers to are things already pending in Congress.

Dr. BAUER. They are pending, but they have not been adopted and I do not think they should be neglected.

Senator MURRAY. I do not see how you can call it a new program if it is already being considered in the Congress.

Dr. BAUER. I do not think that is true for all of it. It is true that the Federal Department of Health has been asked for since 1884, I think. The Hoover Commission, I believe, did recommend that there be an independent agency with a doctor at its head and all Federal activities pertaining to health should be under that particular department.

The National Science Foundation was backed by the American Medical Association. As you know, it was passed by Congress and vetoed by the President due, I believe, to his dislike of the method of selecting a director. I believe that has been straightened out. It is still something not yet accomplished.

On the question of new facilities, it is true that the Hill-Burton Act took care of that to a certain extent, and I think you will recall, I am sure many of the Senators will, that the AMA was very active in promoting the passage of that bill. We feel that it still needs to be expanded. I think they have done fairly well in the provision of hospitals, but they have not done so well with the provision of diagnostic facilities. You cannot expect doctors to go in a community and, after having spent 10 to 15 years of their lives in training, practice medicine which was in vogue 10 or 15 years ago. The community would be better off without him. You have to give him tools with which to work. The expansion of those facilities will to a certain extent attract doctors, if you give them hospitals and diagnostic facilities, although there are other factors.

On the question of public health, I would like to remind the committee that the whole public-health field was originally activated by the American Medical Association and its subsidiaries. I think there is not a single State or county health department in existence today that was not sponsored by the local medical society. The United States Public Health Service itself was originally sponsored by the American Medical Association.

Senator MURRAY. I had understood it grew out of the early establishment of a compulsory system of medical care.

Dr. BAUER. I do not think that is entirely true, Senator, although that may have been a background of it.

Senator MURRAY. The officials of the Public Health Service seem to admit, in their statement that they make, that it came from the early establishment of that system for the care of sailors.

Dr. BAUER. That was merely one phase of public-health activity. Public health now covers a great many other phases, and we have sponsored many of those and still do, and we have been anxious to see the country covered by public-health units.

By so doing, you are going to prevent a lot of need for medical care because you are going to eliminate disease at the source by having proper control of food, water, mosquitoes, flies, and general methods of sanitation.

I think it was brought out in testimony before this committee that there are some 25,000,000 people in this country without any sewerage facilities and some 843,000 rural homes without any toilet facilities whatever. Those are conditions that certainly are breeders of disease and should be remedied.

On this matter of chronic disease in the aged, I would like to say that the American Medical Association, the American Public Health Association, the American Public Welfare Association, and the American Hospital Association are now collaborating in a program to develop a program for the care of chronic diseases and the aged; and that program—the first report will be issued very soon—is being financed at the present time by the American Medical Association, and it was hoped that a program can be set up in each State.

That, to my mind, is one of the crying needs of our present system of medical care, care for the chronic diseases, of which we are going to have an increasing amount in all probability because of this increased span of life. There are too few facilities for the care of chronic disease. They do not need the elaborate set-ups we are required to have for acute diseases such as are prevalent in general hospitals.

They should be, in our opinion, close to general hospitals so that, if the need arises, they may obtain those facilities, but they do not need them 7 days a week or 29 days out of 30 days a month. They can be taken care of under such facilities, most of it very largely custodial care, certainly not more than a third of the cost required for beds in general hospitals, and thereby, when they do occupy those general-hospital beds, keeping acutely ill patients out of those beds.

I do not want to take up too much of your time on this, but this is a set of principles, and the American Medical Association plans to go into more detail on those as to how these things may be accomplished. This is simply a platform, and the various supporting information for it will be available at a later time.

The AMA does not subsidize any of these voluntary-insurance plans. They are not subsidized by the AMA. I did not get that from your statement, but it apparently was made.

Senator MURRAY. Thank you, Doctor.

We will recess until 12:30.

(Whereupon, at 12:45 p. m., the committee recessed to reconvene at 2:30 p. m. on the same day.)

AFTERNOON SESSION

Senator PEPPER. The committee will come to order.

Dr. Lowell S. Goin, of Los Angeles, Calif., on behalf of the American Medical Association, is the remaining witness. Doctor, we will be glad to have you proceed.

Dr. GOIN. Mr. Chairman, I have a short statement to give, but since I have written this statement it has come to my notice that there have been several rather harsh statements made about the American Medical Association, and I would like your permission to introduce a supplemental statement to this one.

STATEMENT OF LOWELL S. GOIN, M. D., PRESIDENT, CALIFORNIA PHYSICIANS' SERVICE, LOS ANGELES, CALIF.

Dr. GOIN. I am Lowell S. Goin, M. D., of Los Angeles, Calif. I am a practicing physician, and I happen to be president of California Physicians' Service, the voluntary health-care plan of California. I had as well say at once that I am in complete opposition to this legislation, and I speak now of the so-called health-insurance bill (S. 1679). I oppose it as a physician because I am persuaded that its enactment would result in great and continuing decrease in the quality of medical care available to our people. I oppose it as an American because I am persuaded that this type of legislation is one of the final steps on the road to state socialism. In this opposition, I am confident that I am supported by the overwhelming majority of American physicians.

Specifically, my opposition is based upon five premises which I propose to state briefly, thereafter developing each one.

No. 1. The assumption that the health of the American people is bad is a false assumption.

No. 2. The assumption that the enactment of compulsory sickness-tax legislation would be in the interest of the public health is totally unfounded.

No. 3. Medical care is not the sole factor in the problem of health, and there are many other things that Government could properly do which would benefit the health of the public far more than the proposed legislation.

No. 4. The cost of such plans, rather lightly passed over by the President and the Social Security Administrator, are totally unpredictable and almost certain to be extremely high.

No. 5. Voluntary health-care plans, which are truly in the American tradition, are giving good medical and hospital care to our people, and must be allowed to develop unhampered by bureaucracy.

Let me now consider these points in its turn.

The health of the American people is bad, perhaps, but it isn't just because someone in the Social Security Administration says it is. Fortunately, it is a matter which may be investigated, and in which conclusions can be based on known facts rather than on emotional statements. Consider then, if you please, that the life expectancy at birth is steadily increasing, being now about 65 years for a male and 69 years for a female. It is materially less in Great Britain, and was still less in prewar German. Both of these countries have long enjoyed the blessing of compulsory sickness insurance.

The death rate from diphtheria per 100,000 of population, in the last year for which comparative figures were available, was 11.6 for Great Britain, 11.4 for Germany, but in the United States, with free-enterprise system of medical care, it was less than 6. Why? Diphtheria is both preventable and curable; why didn't the government-operated medical systems produce a death rate lower than ours?

In the Public Health Reports for August 1946, the United States Public Health Service presents a table showing the death rate from tuberculosis in all countries. In the United States the rate was 47 per 100,000. In England and Wales it was 62. In France it was 137, and in Russia, 160. All of those except the United States have national medical-care plans, but they seem to have been quite unable to equal the performance of the United States.

Some of the most lucid statements which are used to document our bad state of national health are found in Mr. Oscar Ewing's report to the President entitled "The Nation's Health." Perhaps I may be permitted to digress for a moment, and to wonder what magical powers are inherent with civil servants of the Federal Security Agency, which makes them so omniscient in the problems of medical care, and why their opinions so greatly outweigh those of the 197,000 physicians of America whose entire lives have been spent in acquiring professional training to cope with these problems and in the actual coping with them. Mr. Ewing begins with a dramatic statement; a statement made to order for headlines——

Senator DONNELL. Doctor, according to my copy, it reads "breadlines."

Dr. GOIN. Yes. It should be "headlines."

Mr. Ewing begins with a dramatic statement; a statement made to order for headlines: "Every year 325,000 people die whom we have the knowledge and the skills to save." Of these, he says, 170,000 die of communicable disease, and that we should be able to save 120,000 of them. This last figure seems to have been chosen at random, and no documentation is offered. As is not uncommonly the case, the figures are not exactly accurate. In 1945, 177,000 people actually did die of communicable disease, but in 1947 the figure had been reduced to 137,000. That the figure of 40,000 saved by our persent system of medical care does not particularly bolster the case against that system is not mentioned. Perhaps this is purely coincidental. It is a fact that the death rate from communicable disease is the lowest in our entire history.

Mr. Ewing also says that we should be able to prevent 115,000 of the more than 600,000 annual deaths from cancer and heart disease. I am unable to ascertain the reason for the selection of the figure 115,000, and I suspect that it is a purely arbitrary selection. I don't know how many of the deaths were due to heart disease, but it is probably fair to assume that about two-thirds were. Is the implication that these people died because of lack of medical care a fair one? Of course it isn't. Actually, both heart disease and cancer are diseases of the latter decades of life. People eventually die of something, and the more people who live into these decades, the more will die of these diseases. If medical care is the problem, it is curious that the six States with the lowest death rate from heart disease were in the deep South, and that seven of the nine States with the highest rate were in New England. New England has more physicians, more hospital beds, more research centers, and more teaching institutions than the entire deep South. I repeat that it is most curious that the death rates should not fit the amount of medical care available.

Mr. Ewing complains of the shortage of physicians. One wonders why he believes that the enactment of a law bitterly opposed by physicians (physicians' sons are a substantial part of the annual crop of new physicians), and one which experience in other countries has shown to degrade physicians, could possibly increase the number of physicians. I predict confidently that the enactment of this legislation will decrease the number of physicians produced annually, and that it will very materially lower the quality of the young men who enter medicine.

Another ill to be cured by compulsory sickness tax legislation is the inequitable distribution of doctors. There seems to be a vague and hopeful feeling that some magic inherent in this so-called social legislation will persuade doctors to leave cities, where medical schools and libraries are located; where hospital and consultants can be found; and most of all, where a man can have the society of his peers, and go to remote hamlets where none of these things are available and where he can stagnate in intellectual loneliness. Doctors, like other people, locate themselves where they think they are most likely to succeed, and where they will be happiest.

Why anyone should believe that enactment of a law will change these elementals is something of a mystery, but one which would be solved promptly if a paternal government were to direct physicians in choosing their fields of activity. Any such intent is vigorously denied, of course, but the Government of Great Britain has already assumed this right and has announced that more medical care in rural areas would be provided by paying a somewhat larger capitation fee in such areas and, note well, by forbidding doctors to locate in more populous zones.

The assumption that enactment of this legislation would be in the interest of the public health is unfounded. Fortunately for my argument, although unfortunate by other standards, we have a system of so-called compulsory health insurance in actual operation in the city of San Francisco. Set up by ordinance several years ago, it embraces more than 20,000 employees of the city and county of San Francisco. As a public duty, and as a noble experiment, the medical profession of San Francisco consented, almost to a man, to cooperate with the plan which is called Health Service System.

I see no reason to believe that a like system on a national level would function much differently than this "pilot" plan, and this is how it really works; this is what we may reasonably expect to happen once the plan begins to operate nationally.

On May 28, 1947, Dr. A. S. Keenan, medical director of the Health Service Plan found it necessary to address himself to the physicians of San Francisco. He complains of overuse of the system, and urges great curtailment of the care given. I have a copy of this entire letter which I would be glad to file with the committee. The following are his words:

> People in general have more knowledge now on medical subjects. * * * It has brought about many unnecessary visits to the doctor to get treatment for trivial things. Such minor ailments could be treated as well by their home remedies as by their doctor.

There, gentlemen, is a panel system in operation.

The earliest, indeed the only early symptom of lung cancer is a trifling cough. Go home and take some cough medicine.

The only early symptom of gastric cancer is a trifling indigestion. Take some soda.

Next, the medical director complains of clinical laboratory and X-ray expense, and again I quote his words:

> The people in general know little about the results that can be obtained from the help of laboratory tests or the X-ray examination. Please, doctor, turn such requests aside. * * * It would seem that any physician, after taking a short

history of his patient's case and making a routine examination, will find that he can make a diagnosis without leaning so much upon the laboratories and the X-ray departments.

Please note, gentlemen, that early recognition of brain tumors requires laboratory study of the cerebro-spinal fluid, and that early diabetes is recognized by the amount of sugar in blood. After complaining that it costs too much to hospitalize these unfortunate people whose pay checks were subject to compulsory deduction for the service, he says:

> The members of the Health Service System, except in a few obscure cases, do not need any such extensive work.

As is easily possible under the compulsory system, the director solves the problem neatly, thus:

> Hereafter no patient, except in an emergency case, will be entitled to hospital benefits under Health Service System coverage until authorization has been given by the medical director.

There you have the panel system which our planners would like to institute; there you have medical care under compulsory health insurance.

Personal interviews with British physicians who have been so revolted by the system that they have actually fled to the United States to start all over again, and correspondence with others who wish that they could flee, indicates that this is a completely fair picture of so-called compulsory health insurance benefiting the health of the public.

If further evidence is needed, we might let Dr. Nathan Sinai furnish it. Remember that he is an able and ardent proponent of compulsory sickness tax legislation. I quote from his book The Way of Health Insurance, pages 157, 158. These are his words:

> Contrary to all predictions, the most startling fact about the vital statistics of insurance countries is the steady and fairly rapid rate of increase in the number of days the average person is sick annually, and the continuously increasing duration of such sickness.
>
> Various studies in the United States seem to show that the average recorded sickness per individual is from 7 to 9 days per year. It is nearly twice that amount among the insured population of Great Britain and Germany and has practically doubled in both countries since the installation of insurance.

To this he adds:

> It seems to be a safe conclusion that insurance has certainly not reduced the amount of sickness.

This surprises me, since I had naively assumed that the proponents believed that it would reduce the amount of sickness. Certainly, the words quoted comprise an excellent argument against this sort of medical care, although I doubt that Dr. Sinai meant them to be.

A sort of current custom is to use the terms "medical care" and "health" as if they were interchangeable—as though one were synonym of the other. As a matter of fact, medical care is only a small part of the health problem—not even the most important part. Health consists largely in not being sick; medical care consists largely in an attempt to cure or alleviate disease. Nearly all—perhaps all—of the health legislation which has been proposed from time to time has been written by social planners, seldom, if ever, in consultation with physicians. Consequently nearly all it contains is wishful thinking and not too much reality. Too much confidence is placed in preventive medicine, too much earnest belief that periodic health examinations will prevent disease, and all the legislation evidences a complete failure to understand that preventive medicine simply has not yet attained the goals wished for.

To cite a few of the problems: How shall heart disease, except that due to rheumatic fever, be prevented? What sort of health examination will be efficient in its control? How shall we prevent, or even recognize, early brain tumors? Shall everyone with a headache have encephalographic or ventriculographic studies? Shall we do gastrointestinal X-ray studies on everyone with indigestion, and, if so, where shall we obtain the skilled personnel? How are bone tumors prevented, and what periodic examination makes one aware of the pneumonia of next week?

Medical care is, and will for a long time continue to be, the care of the sick, and this, I repeat, is only a fraction of the health problem. Some other fractions to which government might well turn its attention are sanitation, hygiene, health education, adequate diet, good housing, adequate clothing, good working conditions, and patent-medicine control. And there are many others.

If government is sincerely interested in the health of the citizen, why should it not suppress patent-medicine advertising? Why should it not regulate the cults and require that all who wish to practice the healing arts pass the same tests. Why should it not control radio publicity of nostrums, vitamins, and the like? This current legislation is attacking only a small segment of the health problem, and even if it were to accomplish all that its proponents claim, it still would not solve our health problems.

I shall refrain from elaborating in my statement that the costs of the proposed program are unpredictable and are likely to be high. I am sure that there have been or will be witnesses much more able to cope with these problems than I, and I shall leave to them the discussion of the financial problems.

Voluntary health care plans have made a truly phenomenal growth. Thirty-two million people have Blue Cross insurance. Eleven million have medical-care plan insurance. Twenty million more are covered by commercial carriers, and competition by Blue Shield plans have made these carriers offer good comprehensive contracts. If permitted to do so, voluntary plans will ultimately cover a great majority of the American people. If there are rugged individualists who decline thus to protect themselves, must we compel them to do so? I seriously doubt if it is true that half the families in the United States are unable to pay for voluntary coverage. I feel sure that nearly all families can afford it if they are willing to assign a sufficiently high priority to medical care.

In 1947 the American people spent $3,000,000,000 for medical care, including drugs and the services of irregular practitioners. They also spent 3.9 billions for tobacco, 9.4 billions for movies and recreation, and 9.6 billions for alcoholic beverages. Is it seriously argued that this budget could not be rearranged? And, moreover, aren't the same families going to pay for national compulsory sickness tax service? Will it be less painful to have the cost deducted from the pay check? Will the small self-employed person who wishes neither voluntary nor compulsory plan be happier when he is taxed for one?

Voluntary health plans will, if given the opportunity, do the job, and do it better than Government-controlled plans can do. These plans, which already include a very large number of persons, are in accord with our traditional emphasis on personal responsibility, prudence, foresight, and thrift. They have an American dignity which is lacking in the regimentation of compulsory health insurance. They can be and are more economically administered, they can and do give better medical care, and they will be and are supported by thousands of physicians who are bitterly and unalterably opposed to Government-controlled medicine.

In California we have made a good start. Our California Physicians' Service offers medical care at modest costs. Nearly 800,000 of our people have availed themselves of it, and appear to be quite satisfied with it. The Farm Security Administration had a medical-care program for the rural indigent. California Physicians' Service took it over and gave better medical care for less money and to the satisfaction of those giving and receiving the care.

California Physicians' Service has a contract with the State Grange providing medical care for nearly 100,000 farm people.

These activities, which are duplicated in most of our States, are indications of how voluntary plans can meet the challenge, how they are meeting it, and how they will continue to do so with a steady and healthy growth if they are not crushed by the monster of bureaucratic control.

Now, Mr. Chairman, I have a supplemental statement which I would like to read in relation to the activities of the American Medical Association.

During recent weeks and months the American medical profession has been subjected to maliciously unfair abuse from certain advocates of compulsory health insurance, some of whom are officeholders in the Federal Government. Through vicious innuendo, false implication, and outright distortion of fact, deliberate attempts have been made to undermine public confidence in the Nation's doctors, and to make it appear that the American Medical Association is engaged in devious, unethical tactics in its opposition to national compulsory health insurance.

Very few Members of Congress have been a party to this attempted smear. However, you gentlemen probably have heard or read some of the false charges. I believe that you know in your hearts that American doctors, by their very nature and training, would not take part in the questionable activities which have been implied in this scurrilous propaganda. Nevertheless, we need to clear the record with respect to these trumped-up charges.

The American Medical Association—openly, frankly, and honestly—is engaged in a national education campaign to give the people the facts about compulsory health insurance and the facts about voluntary health insurance. We frankly oppose the first and we enthusiastically favor the second. We hope and believe that the American people, given the facts, will agree with us.

In the best American tradition we are taking our case before the forum of public opinion. We are asking for a vote of confidence in the American medical profession and in the American medical system, the finest in the world. We are doing exactly what you gentlemen do at election time. We are using the same avenues of approach—the press, the radio, the speaking platform, pamphlets and leaflets, and all other accepted, ethical means of submitting our case to the people.

The Committee for the Nation's Health, the Physicians Forum, and other groups favoring compulsory health insurance, are conducting a constant propaganda in behalf of it. For 10 years or more, the Federal Security Agency and other Government agencies have been spending unauthorized tax funds to thump the drum for socialized medicine. Now, however, when the American Medical Association finally strikes back at the distorted propaganda of the socializers and Government payrollers, we suddenly hear unfounded and intemperate charges that the American Medical Association is invading Washington with a high-powered lobby and a huge slush fund.

These charges are absolutely false, and those who have been making them know they are false. As you gentlemen undoubtedly know, the Washington office of the American Medical Association is one of the smallest, most conservative legislative offices maintained by any of the national associations in the capital. It is staffed by men of unquestioned integrity, who are highly respected in Washington. Whitaker & Baxter, the public relations organization which is directing our national education campaign, has only one representative in Washington, and he is a press representative, not legislative lobbyist.

The American Medical Association, in its national education campaign, is carrying its case directly to the American people in a grassroots crusade which we hope will reach every citizen in this country. By so doing, we doctors are simply exercising one of the greatest rights which Americans have as a free people—the right of petition as set forth in the United States Constitution. We are exercising that right not simply to protect the medical profession from degradation but to protect the health of the Nation.

The people have a right to know that Government-controlled medicine means inferior medical care doled out according to bureaucratic regulations and rule books, ever-increasing pay-roll taxes, invasion of privacy and freedom of action and destruction of the voluntary health insurance plans which provide good medical care at a lower cost than Government ever could provide it.

In the final analysis, the American people, through their representatives here in Congress, will decide this issue. The objective of the American Medical Association national education campaign is to get the facts to the people. We want them to make their opinions known to the United States Senators and Representatives. We believe you want it that way.

If that is lobbying, it is lobbying in the finest American tradition, and every doctor is proud of his part in the program.

There is nothing secret or devious about this campaign. It is an open-and-above-board public campaign on a vital public issue. The plan of campaign explaining the program has been distributed by the thousands throughout the country—not only to doctors and medical societies but also to a wide variety of interested parties, including newspapermen and magazine writers.

A newspaper commentator referred to this as a secret plan of the American Medical Association. For your information, I am filing a copy of the plan of campaign with your committee.

Senator PEPPER. We would be very glad to have you file it.

Dr. GOIN. I will do so.

(The plan of campaign referred to is as follows:)

A SIMPLIFIED BLUEPRINT OF THE CAMPAIGN AGAINST COMPULSORY HEALTH INSURANCE

(Prepared by Clem Whitaker and Leone Baxter, directors of the national education campaign of the American Medical Association, for the information of State and County Medical Societies; February 21, 1949)

The general strategy, major issues, and fundamental procedures of the campaign were fully outlined during the meeting of State medical society leaders with AMA representatives and the campaign management in Chicago, February 12.

This skeletonized plan of campaign is simply a working blueprint, designed to define the separate responsibilities of the National, State, and county organizations and to outline the basic steps in getting the job in operation.

There is no need to review the general program, except to underline two major objectives:

First. This is an affirmative campaign. Defeating compulsory health insurance is the immediate job, but stopping the agitation for compulsory health insurance, by enrolling the people in sound voluntary health insurance systems, is our most important objective. That's the only way to resolve this problem.

Second. This must be a broad, public campaign—with leaders in every walk of life participating—not just a doctors' campaign. But the work of getting the people alerted and recruited for the battle, that's the responsibility of doctors and their lay representatives.

In setting up State and county campaigns, this basic precept of sound campaigning should be kept in mind:

A simple campaign program, vigorously and carefully carried out, is much more effective than an ambitious, complicated program, with some of the bases left uncovered.

Start with a program you know you can handle with the money and manpower available. Then amplify it later. Tireless personnel work and unbounded enthusiasm for your cause are the most important factors in successful campaigning.

THE NATIONAL CAMPAIGN STRUCTURE

The coordinating committee of the American Medical Association, headed by Dr. Elmer L. Henderson, chairman of the board of trustees, is charged with over-all responsibility for the conduct of the campaign and is the policy-making board of the campaign.

The campaign directors are responsible to the coordinating committee.

The coordinating committee, in turn, is responsible to the house of delegates.

THE JOB AT NATIONAL HEADQUARTERS

The job at national campaign headquarters, eliminating activities which cannot be covered in a thumbnail sketch of operations, breaks down as follows:

1. Development and direction of national planning and campaign strategy.
2. Direction of the national publicity campaign, utilizing largely, the existing, normal channels—the press associations, major newspapers, radio networks and television, the great national magazines, trade publications, newsletters, et cetera. The first objective in this phase of the national campaign will be to get medicine off the defensive and to conduct an affirmative program of education. An intensive campaign for voluntary health insurance will be conducted concurrently with the drive against compulsory health insurance.
3. Direction of the national organization-endorsement drive, designed to mobilize hundreds of the great national organizations in support of medicine's cause. This is a vital step in broadening the campaign into a public crusade. The national headquarters will need constant aid from the State societies in carrying out this part of the program. (Kansas spearheaded the work which brought an endorsement from the American Farm Bureau Federation; California first initiated the drive which brought favorable action from the American Legion national convention.)

4. National coordination of the work in the 48 States, the District of Columbia, and the several Territories. There will be a constant flow of information between National and State headquarters, with reports of changing conditions and vital developments in the campaign. Programs and ideas which have worked successfully in some of the States will be made available, through a national exchange service, to the others.

5. Production of all basic campaign literature and materials, including posters, pamphlets, leaflets, reprints, form resolutions and form speeches, cartoons and mats, publicity which can be adapted for State use, lists of organizations, conventions, etc. This is one of the biggest and most urgent jobs in national headquarters—and the materials will start to flow to the States just as fast as copy writers, artists, engravers, and printers can turn out finished products. As an indication of the tremendous production problems involved in carrying our story direct to the American people, press runs of pamphlets and other materials are expected to total 100,000,000 copies during the first 12 months of the campaign. About one-third of that stock pile of "ammunition" will be released directly through national facilities, with the remaining two-thirds destined for distribution through the States.

6. Organization and direction of a national Speakers' bureau to cover top-assignment speaking engagements. State medical societies are urgently requested to send in the names of dynamic speakers (either doctors or laymen) who are qualified and willing to take out-of-State assignments. Our immediate goal—two top men from each State.

7. Direction of a national women's campaign, geared to bring the support of the major women's organizations and to arouse women throughout the Nation to the threat of socialized medicine.

8. Active cooperation with the prepaid medical and hospital plans and the accident and health insurance companies in an all-out drive to provide the American people with voluntary health insurance coverage. Special literature will be produced for use of the voluntary systems—and the AMA campaign will be closely meshed with the promotional work of the Blue Shield, Blue Cross, and private indemnity companies.

THE STATE MEDICAL SOCIETIES' JOB

One of the first jobs of every State medical society (where it hasn't already been done) will be to organize every county society into hard-driving campaign organization.

Due to varying local conditions, each State, of course, will work out its own campaign structure—and the relationship between the State and county societies in the conduct of the campaign. Many of the States already have scheduled meetings of county representatives, patterned somewhat after the national meeting of State leaders in Chicago on February 12. In other States battle orders are going out by letter, telegraph, and telephone.

AUXILIARIES

Above all, don't overlook or discount the auxiliaries in setting up your State-county campaign organization. The women may be one of the answers to your problem of literature distribution; they certainly should be of positive assistance in getting endorsements from women's clubs, in talking to club editors on the newspapers, in helping to build an effective speakers' bureau. A doctor's wife usually has more time than a busy doctor—and she has a personal stake in this campaign.

FOUR MAJOR CAMPAIGN ACTIVITIES

Let's simplify and streamline this job, so that the essential work can be quickly organized and effectively done. This program can be supplemented in many ways, if money and manpower are available, but there are four major activities that can be carried on at little expense (except in energy), and which will bring quick results in mounting public opinion—and in impact on Congress.

The four essentials are—

1. An effective, State-wide endorsement drive.
2. An intensive publicity campaign.
3. A well-organized, adequately staffed pamphlet-distribution system.
4. An energetic, carefully managed speakers' bureau.

THE ENDORSEMENT DRIVE

Now let's return to No. 1, the endorsement drive, and blueprint what's to be done.

First, put this department in charge of a human dynamo who won't take "No" for an answer, who knows his way around in State or local organizations, who knows how to talk persuasively in personal conversation and how to speak eloquently before a board of directors. Then start him on the job of recruiting helpers—other doctors (and laymen) who will take assignments and stay with them until they get action.

Then get the department at the task of compiling a list of the civic, business, farm, fraternal, political, patriotic organizations—women's clubs, Legion, and VFW posts and other groups which carry influence in your State or community.

To aid you in this work, a list of conventions scheduled in each State this year has been prepared by national headquarters and the list for your State will be mailed to you within the next few days. It will be incomplete at this early period in the year, but it may give you many leads. This State list from national headquarters will give you the following information regarding the conventions listed: (*a*) Name of the organization; (*b*) town where convention is scheduled; (*c*) estimated attendance; (*d*) person to contact, to our best knowledge; (*e*) whether the convention is national, State, or local.

Personal work on the members of the governing board is the basic ingredient for success in winning endorsements. A good speech helps, too—but try to have your board sold on the soundness of medicine's position before you make the speech.

Now, you have won an endorsement. What do you do with it? You put it to work—molding public opinion. Here's how:

If it is from a strong, Statewide organization, you should send copies of the resolution to—

(*a*) President Truman.
(*b*) Your two United States Senators.
(*c*) Your Congressmen.
(*d*) Your State legislators.
(*e*) The AMA Washington Office at 1302 18th St., NW, Washington, D. C.
(*f*) The National Campaign Headquarters, 1 North LaSalle, Chicago.

Then the organization should be asked to work in the campaign—

(*a*) Getting literature to its membership, either through meetings or by use of its mailing list, or both.

(*b*) Using its house organ or news letter for both news and editorials on the issue.

(*c*) Offering its talented members as volunteer speakers on the issue of compulsory health insurance.

(*d*) Sending copies of the resolution to the press and radio.

(*e*) Members on record in one organization can help, too, in presenting resolutions to other organizations of which they are members, and helping to steer them to favorable conclusions.

THE PUBLICITY CAMPAIGN

Many State medical societies already have excellent publicity facilities. Some have trained public-relations men. Others have executive secretaries with newspaper background. Sometimes the editor of the Medical Journal doubles in brass.

Every State, certainly, needs to go to the newspapers with its story early in this campaign—and if facilities aren't available, they should be established.

Endorsements make news. Statements by leaders in the State or community make news, particularly if they are hard-hitting statements, tied to current developments in the battle. Actions by State and county societies make news—and should be publicized so that the people will have no doubt of medicine's position. National publicity releases can be turned around and given a State treatment. Your speakers' bureau will make news as its members appear before various meetings and organizations.

Above all else, set up a press committee to call on every newspaper and get the real facts in this case before the editor. There are 12,000 newspapers in America. Every one of the 12,000 should be called on, preferably by a doctor who knows the editor and has his confidence. American medicine needs vigorous editorial support in this campaign.

THE PAMPHLET-DISTRIBUTING SYSTEM

Every reception room in every doctor's office should be a unit in the pamphlet-distribution system during this campaign. Initial shipments of pamphlets from national headquarters to the State societies will be made on the basis of 50 pamphlets per doctor—and it is vital that facilities be set up well in advance to get this material into circulation.

National headquarters will, on request, ship supplies directly to the county societies, but we feel that most States will rightly prefer to keep that liaison with their own counties.

THE SPEAKERS' BUREAU

There are many nonspeaking speakers' bureaus in State and county medical societies, but this is the time to have an energetic, working speakers' bureau—and no time should be lost in recruiting able men (both doctors and laymen) for speaking assignments in this campaign.

Form speeches will reach you shortly from national headquarters. These should be used as a guide to the effective arguments of the campaign, and may be redrafted or rephrased to fit the speaker, the community, or the audience.

Train your speakers. Arm them with facts, because this is a campaign in which every speaker needs to be prepared for a heated question-and-answer period. If the speaker is a doctor, encourage him to speak from the standpoint of the patient's welfare, not his own. And above all, get laymen speaking for medicine in this fight. Veterans and farmers, civic leaders and tax authorities, druggists and dentists, teachers and club leaders, State and local officials—these are the allies medicine needs on the speaker's rostrum in this campaign.

Then, when you have an effective speakers' bureau, offer the services of your speakers to major organizations throughout the State. Put a good organizer in charge of your schedule, so that your speakers have adequate time to prepare—and so that they get a reminder a day or two in advance of the appearance.

Now the clincher. Every speaker should learn how to close his sale—and build up to an endorsement, in addition to an ovation. That's effective campaigning.

THE COUNTY MEDICAL SOCIETIES' JOB

The preceding outline of the four major campaign activities for States applies as well to each county campaign.

In addition to those activities, early attention should be given to the following:

1. Every county medical society should adopt a strong resolution against compulsory health insurance and should send copies of its resolution to—

(*a*) President Truman.
(*b*) Its two United States Senators.
(*c*) Congressmen from its own district.
(*d*) State legislators from its own district.
(*e*) Its State campaign chairmen at the State medical association office.
(*f*) The AMA office at 1302 Eighteenth Street NW., Washington, D. C.
(*g*) The national campaign headquarters, 1 North La Salle, Chicago.

Copies of the resolution to every Congressman and Senator should be accompanied by a letter signed by the county medical society president asking for a reply, so that the legislator's position can be made known to the doctors of his district. Copies of all replies should be forwarded to the national campaign office and to the Washington office of AMA as rapidly as they are received.

2. County society secretaries should encourage the personal physician of every Congressman and every Senator to send a personal letter to his patient, the Congressman, or the Senator, telling him of the danger of socialized medicine, and asking for his help in defeating the compulsory health-insurance program.

THE DOCTOR'S JOB

The individual doctor's job in this campaign is of paramount importance.

The AMA and the State and County medical societies can provide an effective framework for the campaign, but every doctor who values his freedom in practice needs to work at keeping that freedom crusading every day of the week.

Doctors, who have devoted their lives to fighting physical ills, must do double duty until this issue is resolved—and help in treating the ills of the body politic.

Every doctor needs to talk to every patient who is able to listen—and tell him the truth about political medicine, how it destroys the quality of medical care, how it breaks down the physician-patient relationship, how it raids the pocketbook of every taxpayer, and how it threatens personal freedom.

Every doctor, too, needs to encourage patients to get good, sound, voluntary health insurance for their own protection and the protection of their families.

The doctor's job in the campaign will be more fully outlined in a special pamphlet which will be mailed direct to every member of AMA throughout the Nation.

No group of men can reach the people of America more quickly or effectively than the doctors of America—and doctors can cure this sickness, if they fight it as they would any other plague which threatened their country or community.

This is an emergency—and we believe the doctors of America will measure up to it.

Dr. Goin. Nearly 14,000 copies of this have been distributed all over the United States. There is nothing in our program which is secret—and you may have copies of any material we are issuing simply by requesting it.

Yet, at least one radio commentator and one Congressman, in recent public utterances, have quoted from these widely publicized materials, attempted to give the impression that they were revealing "shocking" information from "secret" documents. Apparently depending on the same unreliable source for their information, both men referred to the fact that American doctors intended to present their case in newspapers and magazines, and that doctors were urged to write letters to any Senators or Representatives who were their personal patients. These alleged revelations, gentlemen, are nothing short of ridiculous. Since when is it a crime to submit material to newspapers and magazines? And since when are doctors deprived of the ordinary right of any citizen to write to the men who represent them in Washington?

If there is any need for a congressional investigation of lobbying, it is for an investigation of the Government lobby which has forced the American medical profession to strike back in defense of its good name. The Harness committee reported to the House of Representatives in 1947 that at least six agencies in the executive branch of the Federal Government were using Government funds in an improper manner for propaganda activities supporting compulsory health insurance. The Federal Security Agency alone has become a tremendous propaganda agency for Government medicine.

It seems very strange to me that when I appear anywhere to speak on this subject, some representative of the Federal Security Agency often shows up in the same town, speaking in favor of Government medicine. Who pays for this? Has Congress authorized the use of Federal funds for these propaganda lecture tours? Is the Federal Security Agency usurping the rights of Congress, the regularly established legislative branch of the Government?

As I mentioned a moment ago, Government agencies lobbying for compulsory health insurance—some of them for 10 years or more—have forced the American Medical Association to embark on its national education campaign. Although the great bulk of these campaign activities and expenditures do not constitute lobbying under the terms of the Federal Lobbying Act, Public Law 601, by the Seventy-ninth Congress, in the opinion of our legal counsel, the campaign directors have registered according to the letter of that law. A report of expenditures for the first quarter of 1949 already has been filed, listing separately every item over $10,000. We invite the closest possible scrutiny of all reports and records.

More than half of the time, effort, and money in this campaign will be used in affirmative, positive action, designed to aid in the development of the voluntary prepaid health systems. American medicine is far more concerned with solving a problem than with simply defeating a bill for compulsory health insurance.

The ultimate, long-range objective of this campaign is to make the American people more and more health insurance conscious. We want them to know that sound protection against the costs of illness is available under existing voluntary health insurance plans, at reasonable rates far below the inevitable high cost of a compulsory, tax-supported program.

We want the people to know that the many different hospital, surgical, and medical insurance plans are working constantly to extend their benefits. Already there is a tremendous demand in this country for voluntary health insurance. The greater that demand can be made, the quicker this problem will be resolved. The great need in America is not for compulsion but for a general realization by the people that health protection is an essential item which should be given its proper priority in the family budget, and which can be so budgeted without undue financial burden.

I think I am correct in saying that several members of this committee feel the same way. A number of you gentlemen have shown a definite interest in the great progress of voluntary health insurance, and you are sponsoring legislation embodying principles which we fervently support. We think you are on the right track to an American solution of this problem.

The American Medical Association national education campaign, by alerting people to the wisdom and necessity of handling this problem themselves, is making a contribution toward the further improvement of our national health. We believe it also is performing a service of value to Congress, by making it unnecessary for you to levy new payroll taxes and launch this Nation into a dangerous experiement in Government medicine. Such an adventure would impair or destroy not only the American medical system but also our national financial stability. There are other, more sensible ways to solve our problems in medical economics.

Let's stop the small-boy name-calling. Let's settle this issue like adult Americans, using the best medical and economic tools that exist on the face of this earth.

Senator Pepper. Does that complete your statement, Doctor?

Dr. Goin. Yes.

Senator Pepper. I would like you to know, Doctor, that I certainly recognize the right of every citizen to advocate any honorable course of action as the public policy of this country, and certainly no one has any right to condemn anybody who advocates what he honestly believes to be in the public interest if it meets reasonable standards of merit.

I subscribe to your hope that we may get away from the practice of name-calling. Would you go so far as to say that would prevent you folks who do not like our national health insurance program to quit calling us the advocates of socialized medicine?

Dr. Goin. Well, Senator, there we get into an exercise in semantics, just what socialized medicine is. It is a nice, convenient name, and people know what it means.

Senator **Pepper**. The unfortunate connotation of it is that it suggests, and a lot of people charge, that anybody who advocates what they call socialized medicine is open to doubt as to whether they are good Americans, or whether they are trying to import communism or something else into this country.

I think it would clarify the atmosphere a good deal if we could discuss this on the merits of it. As I said to a medical society in Jacksonville when I spoke to them, I will not accuse you of being selfish and acting out of pecuniary motives if you will not accuse me of being a Socialist and acting out of sheer political motives.

We will all try to approach this on the basis of the merits of it, and I hope we can do it.

Doctor, if you do not care to answer this question, you do not have to. Do you object to questions relating to what the newspapers have publicized as the levy upon the members of the medical association?

Dr. **Goin**. Not at all.

Senator **Pepper**. Tell us, what is the amount that the members are called upon to contribute to combat this national health insurance?

Dr. **Goin**. Let me explain to you first that the American Medical Association has no power to impose any assessments, and it has not done so. It has urged every county society so to do, and they urge them to assess the members in the amount of $25 per head.

Senator **Pepper**. How much money was that expected to raise if all the members contributed the $25?

Dr. **Goin**. I understand about $3,000,000.

Senator **Pepper**. About $3,000,000. Could you tell us, or have you any objection to telling us if you know, what success you have had so far in raising that amount?

Dr. **Goin**. I do not really know, but I inquired yesterday and was informed that my informant believed that about one and a half millions had been received. However, I do not guarantee that figure.

Senator **Pepper**. Now, was this $25 that had been asked of the county societies to request of their members just for 1 year, or for the course of the campaign, or for the present?

Dr. **Goin**. I understand it is for the campaign.

Senator **Pepper**. Doctor, I had a letter the other day from a citizen in my State, telling me that he wanted me to understand why it was that he sent me a card which he had previously sent to me to which he had subscribed his name.

I believe it was in printed form, and this card very vigorously opposed the national health insurance program. His statement to me was that his wife was going to be operated upon, or had been operated upon, and he was in the office of the doctor who had performed, or was going to perform, the operation.

These cards were there in the doctor's office. The doctor presented him one and asked him to sign it, and he felt some hesitancy in not signing it because he was in the office of the doctor who had operated, or was going to operate, upon his wife. Therefore, he signed the card and gave it to the doctor's assistant, and presumably it was sent in to me. It was. He was now writing to explain to me that that did not represent his views at all.

Now, do you know whether doctors are making a practice of having these cards in their offices and inviting or suggesting to their patients that they send them in to Members of Congress?

Dr. GOIN. I have not seen any such cards.

I should think the person who carried it was rather a weak character. I do not believe I would sign a card if you asked me to.

Senator PEPPER. I do not want to pass judgment upon that. I suppose it depended upon the situation at that time.

He explained that he felt some embarrassment not to sign it.

Dr. GOIN. Maybe he thought the doctor would operate somewhat less skillfully if he did not sign it.

Senator PEPPER. Doctor, in your testimony, on the second page you referred there to the large "death rate from diphtheria per 100,000 of population, in the last year for which comparative figures were available." It was "11.6 for Great Britain, 11.4 for Germany, but in the United States, with a free-enterprise system of medical care, it was less than 6.0." Why?

Now, what year did you have in mind there?

Dr. GOIN. I believe the year 1939.

Senator PEPPER. The year 1939?

Dr. GOIN. Yes. I should imagine that it has been fairly level for some time. I meant, Senator, that the death rate for diphtheria in the United States is 1.5; 6 as a record of a single city.

Senator PEPPER. Did they have compulsory health insurance which included the treatment for diphtheria in Germany for 1939?

Dr. GOIN. I think so.

Senator PEPPER. You are not sure?

Dr. GOIN. They have had it since 1884.

Senator PEPPER. Did the health plan in effect in England in 1939 include treatment of diphtheria in children?

Dr. GOIN. It must have. It included sicknesses of all insured people.

Senator PEPPER. I do not know whether or not it is correct, but my advice is that it was only included in this system that went into effect last year in England.

Now, 1946 is the year you used for comparison with respect to tuberculosis?

Dr. GOIN. Not I; the Public Health Service.

Senator PEPPER. Well [reading]:

> in the United States the rate was 47 per 100,000; in England and Wales it was 62; in France it was 137, and in Russia, 160.

Of course, the year 1946, in respect to England, France, and Russia was pretty close after those countries had been through 4 years of quite serious war; was it not?

Do you think that is a good year for comparison?

Dr. GOIN. Perhaps not. It is the data I had available from Public Health Service.

We had been through a pretty serious war in 1946.

Senator PEPPER. I do not think you would suggest that conditions were as severe in the United States as in those countries?

Dr. GOIN. No; I would grant that.

Senator PEPPER. Now, you refer on page 3 to the death rate from communicable diseases. Would you say that the United States Public Health Service and the health services of the States and counties—that is to say, what you might call public doctors and public authorities—have had some influence in the reduction of that death rate?

Dr. GOIN. I have no doubt about it.

Senator PEPPER. So all of that is not attributed to the private practice of medicine in the country?

Dr. GOIN. No. The figure was quoted so triumphantly in Mr. Ewing's report that I thought it might be well to debunk it slightly.

Mr. PEPPER. Now, I am advised, Doctor, that the statement of Dr. Keenan, medical director of the Health Service Plan in San Francisco—the fuller statement from which you took a quotation reads as follows—do you have the full statement there?

Dr. GOIN. Yes.

Senator PEPPER. I am advised that the following is in the statement:

> The members themselves as well as the doctors are to blame for the no doubt thoughtless increased cost——

Dr. GOIN. Just a second, sir, until I find that place.

Senator PEPPER. It is on page 5 of your statement.

Dr. GOIN. How did it begin?

Senator PEPPER (reading):

> The members themselves as well as the doctors——

Dr. GOIN. Yes; I have the place.

Senator PEPPER (continuing):

> The members themselves as well as the doctors are to blame for the no doubt thoughtless increased cost of clinical laboratory and X-ray expense. The people in general know little about the results that can be obtained from the help of the laboratory tests or the X-ray examinations. Please, Doctor, turn such requests aside; explain to them that when needed you will have the examination made.
>
> In this regard I now make an earnest appeal to the doctors to limit their laboratory tests and X-ray examinations to just what is necessary to make a diagnosis.

Now, it would seem there that Dr. Keenan did not suggest anything except that the doctors should be the judge of what was necessary, rather than perhaps some idea that the patient had which might not be medically sound.

Dr. GOIN. But Dr. Keenan was not one of these monstrous bureaucrats who was going to deny treatment as distributed by the members of the plan.

Senator PEPPER. I had an impression to the contrary from your excerpt.

Dr. GOIN. I think the complete sentence is:

> Please, doctor, turn such requests aside; explain to them that when needed you will have the examination made.

Now, that is a statement directed to the physicians. They took it so. The medical profession in San Francisco took it so, and almost to a man they resigned from the service.

Would you care to go on? I did not want to take the whole statement. If you do not have it, I will be glad to read it to you.

Senator PEPPER. I would be glad to have you read any part of it you wish to read.

Dr. GOIN (reading):

> In this regard I now make an earnest appeal to the doctors to limit their laboratory tests and X-ray examinations to just what is necessary to make a diagnosis. It would seem that any physician, after taking a short history of his patient's case and making a routine examination in his office—

he is referring now to laboratory and X-rays—

> particularly as regards the X-rays, because I have in the histories the reports from the X-ray laboratories. I feel safe in saying that between 50 and 60 per-

> cent of them are unnecessary. The survey of the G-I series and the barium enenra examinations revealed that these were negative in nearly 75 percent of the cases.

Now, Senator, that is a completly idiotic statement. If you say that 25 percent of the cases were negative, how do you know which one out of the four is going to be negative?

Senator PEPPER. I do not think he denied making the examinations when necessary, Doctor.

Dr. GOIN. I do not think he denied it absolutely, but he scolded them about it.

Senator PEPPER. You do not deny there is a need for eliminating some of these examinations when not necessary?

Dr. GOIN. No; but I do not want anybody telling me when I can make these examinations.

Senator PEPPER. Doctor, have you made X-rays of everyone in your office?

Dr. GOIN. No; but I do not want somebody's judgment interposed between mine and the patient.

Senator PEPPER. I thought he made it clear that the judgment to be exercised—when he said:

> Please, Doctor, turn such requests aside; explain to them that when needed you—

that is you, the doctor—

> will have the examination made.

Then he says:

> In this regard I now make an earnest appeal to the doctors to limit their laboratory tests and X-ray examinations to just what is necessary to make a diagnosis.

Dr. GOIN. Then he discloses what is necessary in the next paragraph by saying that only 25 percent of the G-I and barium enemas were necessary because only 25 percent had any results. The rest of them did not show any results. Perfectly silly attitude for him to take.

Senator PEPPER. Under the voluntary plans, including the doctors' plans, can any patient get any service that he requests without having it approved by the doctor, if necessary?

Dr. GOIN. No; I do not think any person could under any plan. I think that is the doctor's judgment.

Senator PEPPER. Well, somebody in respect to the Blue Cross and the other prepaid voluntary plans that are in effect—does not somebody exercise some cautionary discretion, just not let the expenses run away from the plan; just the doctor?

Dr. GOIN. Now, I can only speak with authority for California Physician Service. No one can tell me not to have an X-ray study made if I am one of the subscribers.

Senator PEPPER. Does every patient who wants a laboratory test and X-ray test, regardless of the doctor——

Dr. GOIN. No; it is the doctor's opinion—but not some other doctor's.

Senator PEPPER. I get the impression from the case you were talking about in San Francisco that it was the custom that anybody in the doctor's office who wanted the doctor to give them an examination got the examination, and the Director said: "Do not do this, unless the doctor finds it necessary for the diagnosis."

Is that not what he said?

Dr. GOIN. No; I do not take it that way. I think it makes a perfectly logical story out of this. He says, first of all, it costs too much. In the second, third, and fourth paragraphs he expressed himself as being unhappy about the costs.

On the next page, he says that the members have continued to grant too much medical service. He says in most cases it is not necessary; that they could be as well treated by home routine—

I cited you two of those minor ailments, a cough and indigestion.

If we are going to have health care, let's try and have it. Is this better health care when the patient is urged to treat his condition at home?

Senator PEPPER. The San Francisco plan may or may not have been a good plan; I suppose the local people would be better judges of that. I merely wanted to call attention to some other lack that was in Dr. Keenan's statement as well as that which you had quoted.

Now, doctor, you spoke that medical care was only a small part of the medical problem, and you spoke about the value of good housing and school-lunch programs and decent wages and adequate clothing, and all that sort of thing. Because those do contribute to better health, has the American Medical Association made it a policy to support those measures when they have been before Congress?

Dr. GOIN. I do not think it is a matter of concern with the American Medical Association. It is a matter of concern with every doctor as a citizen, but not a proper attitude for a medical association.

Senator PEPPER. Although they would be in the interest of the better health of the people?

Dr. GOIN. I think that is perhaps going a little bit too far. None of us have enough practical knowledge.

Senator PEPPER. We have tried to get an increase in the school-lunch program so the school children of the country could get at least one nutritious meal a day. Certainly, if we had been able to turn to a strong appeal to the Congress made by the American Medical Association in the interest of the children——

Dr. GOIN. Perhaps the association was remiss in not doing so.

Senator PEPPER. Perhaps in the future I will know where to turn for help.

Now, Doctor, I am advised that the following is an excerpt from a critical analysis of sickness insurance, page 22, a medical publication reprinted from the American Medical Association Bulletin of April 19, 1934. American Medical Association, 55 North Dearborn Street, Chicago, 1938. And the heading is: "Is compulsory health insurance necessary?" I am quoting what I understand to have been the statement that was made by the American Medical Association or some branch of it.

> Without some form of compulsion, voluntary insurance fails of its objective of distributing the cost of sickness among large classes of the population. The young and healthy will not join, and the aged and sick apply; if accepted, it raises the cost to a prohibitive point, and if rejected, it removes protection from those most in need. Sickness insurance in the low-income classes is almost compulsory.

Most of the so-called sickness plans have a large element of compulsion in them. This may take the form of making the membership a condition of employment in a labor organization or even to a certain degree a condition of citizenship, as formerly in Denmark. That all such indirect compulsion finally proves ineffective would seem to be indicated by the recent action in Denmark, this country which has long bene hailed by the defenders of the voluntary system as an example of successful operation, without direct legal compulsion no one has benefited materially.

It has adopted a thorough compulsory system which went into effect October 1, 1933.

Now, was that ever the point of view of the American Medical Association?

Dr. GOIN. I could not say. I am unfamiliar with the material, but I would point out that in 15 years anyone is entitled to change his mind. We develop experiences and know more about it in that time.

Senator PEPPER. I was informed that was the view of the American Medical Association in 1934 and 1938.

Dr. GOIN. I can hardly believe it was the view of the association. Some one of these departments of economics may have published that. I am not familiar with the house of delegates ever having taken any action on it, and I have been a member of the house of delegates for many years.

Senator PEPPER. I am advised that it came from the bureau of medical economics of the American Medical Association, and that it represented their view.

Dr. GOIN. Represented the view of the bureau of medical economics. It could not represent the association unless the house of delegates endorsed it.

Senator PEPPER. You were speaking awhile ago about the objective in the discussion of this matter, and I believe the first time you called the national health insurance plan the national sickness plan in your statement. Are you now designating the national health insurance as the national health sickness plan?

Dr. GOIN. Without the word health.

Senator PEPPER. You do not mean we are trying to tax health?

Dr. GOIN. I want to cease calling this health because I think it has little to do with health and nothing to do with insurance. It is certainly a tax provided for sickness, so I just like that name.

Senator PEPPER. Well, have you any suggestion as to a name that we should apply and one that you should apply?

Dr. GOIN. No; we have just one common name—sickness tax.

Senator PEPPER. You would call it sickness tax? You think a bill that is designed to provide medical care for those who are sick should be called the sickness bill?

Dr. GOIN. It seems to me like a good name. People do not like to talk about sickness and death and sin and so forth, but they do like to talk about God and mother and health so they make nice words to put into a bill, but I do not hold much with them.

Senator PEPPER. And you do not think it is insurance?

Dr. GOIN. Where you tax the people a part of their pay roll or their income, no, I do not.

Senator PEPPER. Doctor, you probably suggest that the treatment of disease and the care of patients who are ill is the prerogative of the skilled person; that is to say, the doctor, and that the layman should not interfere with the administration of medical care to the patient; that is correct, is it not?

Dr. Goin. I would believe that; yes.

Senator Pepper. Now, are doctors also specialists in economic matters?

Dr. Goin. Oh, no.

Senator Pepper. Are they necessarily specialists in political and public affairs?

Dr. Goin. Not at all.

Senator Pepper. Do they have any knowledge of the principles of economics and public administration that is necessarily superior to that of any of the rest of the citizenship?

Dr. Goin. Possibly a few do, and I am not so terribly confident in the professors of economics after I heard the testimony this morning.

Senator Pepper. What I was getting back at, I was wondering whether or not the doctors were justified in going into the matter of how the people of the country could pay for the medical care they get; if the doctors were justified in denying the people the right to survey this field and to decide the best plan by which the people can pay the doctors for their services.

Dr. Goin. Senator, I do not believe they ever dreamed of denying that right.

I think all that the doctors say is that they feel it is their duty, since they presumably know more about medical care than the rest of the people, to point out to the people and to the people who make our laws—you—that in our professional judgment this will not be a good way to serve the health of our people.

Senator Pepper. Have you ever written any legislation on this subject? Are you a specialist in the field of legislation?

Dr. Goin. Oh no, sir.

Senator Pepper. Are you a specialist, yourself, in the field of economics?

Dr. Goin. No, sir.

Senator Pepper. Are you a specialist in the matter of security, such as social security?

Dr. Goin. I will confess that I am just a doctor and have no other qualifications.

Senator Pepper. Is there anything in this bill about telling you how to treat a patient as a doctor?

Dr. Goin. No, Senator, there is not, but I reflect the German insurance law. When it was written it contained 17 sections, and in 1933 it contained 3,300 sections. The British compulsory nationalized medical service was not a very elaborate law, but it is necessary for the Health Minister to have a book of regulations 1,300 pages long.

If you will permit me, I will illustrate how British doctors have been fined for not treating in the manner they felt wisest because that method did not conform to the regulations.

Senator Pepper. I will be glad to.

Dr. Goin. British doctors have been fined for using diethylstilbestrol instead of phenobarbital.

Senator Pepper. Now, you will have to explain that.

Dr. Goin. Stilbestrol is a synthetic form of an endocrin that is secreted by women's ovaries. It is what makes them women, of course.

When the woman approaches the menopause this secretion ceases. The woman's body then cries out for this substance and they are very unhappy.

You can use substitution therapy by giving the patient stilbestrol and replace the substances now missing in the body, and then slowly decrease it over a year or so until the woman's body becomes used to the lack of this substance, or you can simply dull all those symptoms by giving her phenobarbital.

Stilbestrol is expensive and so the British doctors are not allowed to prescribe this. I would not consider it a very good thing to do.

Senator PEPPER. Would you give us that case so we could make some inquiry into this incident?

Dr. GOIN. I could not give you the case. I can probably find it for you, though.

Senator PEPPER. So we could see the whole situation surrounding that decision.

Dr. GOIN. I cannot give it to you now but I can find it for you and I would be very glad to send it to you.

Senator PEPPER. Of course, we take your word for it, but at the same time we would like to know the whole situation, and there may be something on the other side.

Dr. GOIN. I do not know whether or not there is. I am just speaking from memory, but I will be glad to document it and send it to you.

Senator PEPPER. Will you write out the name?

Dr. GOIN. The medicine?

Senator PEPPER. Yes, phenobarbital and the other.

Dr. GOIN. It is diethylstilbestrol.

Senator PEPPER. Now, your information is that some doctor was fined. Was this one doctor or more than one?

Dr. GOIN. Oh, no. I think it is many. It was simply forbidden by their book of regulations to use it; phenobarbital is directed for use.

Senator PEPPER. Your testimony is that a regulation forbids the administration of one of these drugs and requires the administration of the other drug. It is very pertinent to know what the facts about this are.

Dr. GOIN. I will send you a citation about that.

Senator PEPPER. Have you any other instances with reference to the doctor's treatment of the patient?

Dr. GOIN. As a matter of fact, I believe Dr. Davies could testify to this before this committee. Dr. Davies has lectured widely and is a fellow of the Royal Academy, an experienced practitioner of some 20 or 25 years, who came here from England as an intern in one of our hospitals. I think he can tell you at first hand.

Senator PEPPER. Has he been invited?

Dr. GOIN. I think he has.

Senator PEPPER. Would it be improper if we invited somebody from the Government to come and give their views also?

Dr. GOIN. Certainly not.

Senator PEPPER. The doctor you spoke of is no longer living in England?

Dr. GOIN. No, he lives in Santa Monica. I understood he had been invited to testify; I am not sure.

Senator PEPPER. But as one member of the committee, you would not think it improper if we called somebody from the Government side, if we can get anybody to give their views of the matter?

Dr. GOIN. Of course not. All we want to know are the facts.

Senator PEPPER. Certainly.

Now, doctor, as I understand, what we call the national health insurance law is primarily a plan by which people are required to take out insurance; that is, to become members of the system by paying a part of their income periodically, and, as I understand it, there is no compulsion upon the patient with respect to the choice of doctor, or any compulsion upon the doctor, either to come into the plan or with respect to the acceptance of the patient.

It does contemplate, obviously, that there would probably be some agreement as to a scale—some general agreement at least to a scale—of fees that the doctors might charge and that the hospitals might charge for medical services that might be rendered for the patients.

You understand that also; do you not?

Dr. GOIN. I understand that is proposed as one of the alternatives, but I do not think it will ever be done.

Senator PEPPER. You mean that if the plan should be adopted there would be no agreement between the agency and the hospital—between the doctor and the hospital—as to what their charges would be?

Dr. GOIN. No. On the contrary, the law provides that the Board may make a price for hospital accommodations, and it does not say anything about the hospital agreeing to it. It just says that the Board shall fix a price and that they will be based upon the plan. What would happen to the majority of our private hospitals who do not have such accommodations?

Senator PEPPER. It is probable that if the plan were adopted there would be some general agreement between the agency and doctors as to the fees they would render for covered patients.

Dr. GOIN. That there will be a capitation fee set up. Every expert that you have had before this committee who is in favor of compulsory health insurance has testified that only the capitation fee is practical administratively, and that a fee scale and a fee-for-service basis would wreck the whole plan.

I do not have the slightest doubt and I do not think anything but a capitation plan would be adopted.

Senator PEPPER. Does not the language of the law itself allow the county medical society—would you turn to the language of the law that pertains to the matter.

It says there shall be a fee schedule.

Dr. GOIN. But, as a matter of fact, that will not be practical and it will not be done. I know what the law says. That is what it says.

Senator PEPPER. What I am getting at is we have to concern ourselves with what the law says.

Page 118, section 718 says:

> Agreements for the furnishing of medical or dental services (other than specialist services) as benefits under this title shall provide for payment—
>
> (1) on the basis of fees for services rendered as benefits, according to a fee schedule;
>
> (2) on a per capita basis, the amount being according to the number of individuals eligible for benefits who are on the practitioner's list;
>
> (3) on a salary basis, whole time or part time; or
>
> (4) on such combinations or modifications of these bases, including separate provision for travel and related expenses, as may be approved by the

> State agency; according in each health-service area as the majority of the medical practitioners or of the dental practitioners, respectively, under agreement to furnish such services shall elect—

et cetera.

Senator Taft, I am referring to page 118.

The law gives the majority of the practitioners there the right to determine whether compensation shall be on a fee-for-service basis or one of these other methods; does it not, in the language I have just read?

Dr. Goin. That is what it says.

Senator Pepper. The reason I was asking these questions, Doctor, is this: What is the situation at the present time with respect to Blue Cross and the other prepayment plans? Is it some agreement as to a schedule of fees and hospital charges between the doctors and the hospitals and the authorities handling these plans?

Dr. Goin. There is an agreement between the hosiptals and the Blue Cross. There is an agreement between the doctors and the Blue Shield, but please note that they are agreements made between doctors—plans the doctors themselves have taken up.

Senator Pepper. Is the Blue Shield run by doctors? It is simply a nonprofit organization; is it not?

Dr. Goin. Yes.

Senator Pepper. Is it operated by doctors or laymen?

Dr. Goin. I could not say.

In our association of the voluntary medical care plan, it is operated by doctors. We have laymen on our board. We have their advice, and so forth.

Senator Pepper. But is it your understanding that Blue Cross is operated by doctors or laymen?

Dr. Goin. Blue Cross is operated almost entirely by laymen.

Senator Pepper. Now, is there any agreement between Blue Cross representatives and hospitals as to what bills, what fees, the hospitals will charge covered patients for the services they render?

Dr. Goin. Surely.

Senator Pepper. That is an existing practice, is it?

Dr. Goin. Yes.

Senator Pepper. Currently carried on between the hospitals and the Blue Cross representatives, although Blue Cross representatives are generally laymen?

Dr. Goin. Yes.

Senator Pepper. Now, there is an agreed schedule of fees at the present time in practice in covered use between the doctors and Blue Shield, which is a voluntary association with respect to medical services, comparable to what Blue Cross is with the respective hospitals?

Dr. Goin. We ought to straighten one thing. The Blue Shield is the name of an organization of medical-care plans for the purpose of exchanging information and helping each other in general. The agreements are between the doctors and the various medical-care plans and not really with Blue Shield.

Senator Pepper. Yes, I know, but these Blue Shield—let us say that whatever the plans are at the present time, the voluntary plans under which you receive medical care on a prepayment basis, are these plans generally administered by laymen or doctors?

Dr. GOIN. The executives are generally laymen.

Senator PEPPER. The executives are generally laymen.

Now, these executives are the ones who enter into the agreement with respect to the schedule of fees by the doctors?

Dr. GOIN. Not in our plan, oh no.

Senator PEPPER. What do you mean—your plan?

Dr. GOIN. California Physicians Service. We are the second biggest plan. We set up the fee schedule; the executives do what we tell them.

Senator PEPPER. That is an association, however, set up by the doctors in California?

Dr. GOIN. Yes.

Senator PEPPER. Not like these voluntary plans that are set up by laymen and not doctors?

Dr. GOIN. Well, it is a voluntary plan. It just happens to be set up by doctors.

Senator PEPPER. What I am getting at, doctor, is that a lot of doctors think it would be very horrible to have any agreed scheduled fees between the agency representing the national health insurance program and the doctors for the rendition of professional service. I was merely asking if that practice is not already prevalent in respect to the voluntary plans that are in existence.

Then I was next going to ask you, in the case of commercial insurance companies—doctors who practice, who render services to patients which are paid for by commercial companies—do they have any agreed schedule of fees for such companies?

Dr. GOIN. No; I believe not. It is true in the voluntary plans in the Blue Shield organization, but I do not think it is with commercial carriers; nearly all of them indemnify. The doctor has no contractual relationship with them at all.

Senator PEPPER. They generally indemnify the patient that is covered?

Dr. GOIN. Yes.

Senator PEPPER. Is not that a principle that could be called a regulation here that might affect the doctor, simply to require him, if he comes into this system and renders medical care under the system, to agree with the agency with respect to schedule of fees generally, after the county medical society has determined what kind of payment shall be the custom?

Dr. GOIN. Senator, I think that the doctor would feel a good deal better if it were indicated who would negotiate with him, and how. Primarily I do not think the doctor is concerned about his fee schedule and his fees; I think he is concerned about the Federal degradation of the practice of medicine which he believes will follow the enactment of such law.

Senator PEPPER. Doctor, what is in this bill that suggests the degradation of the medical profession?

Dr. GOIN. I do not think there is anything in the bill but just common sense and observation but that is just the initial bill. There will be a series of directives and rules following this. Once you have committed yourself to it, you will not be able to back out. That is what we feel sure will happen

Senator PEPPER. Now, you expect Congress to continue to sit here in Washington, do you not, for a long, long time, in this country?

Dr. GOIN. I certainly hope so.

Senator PEPPER. And you do not doubt that Congress has authority to make any changes in this law, or any other law that it has passed, that it might care to make; and that Members of Congress come from the States and from the districts so they would be accessible to the complaints of their constituents if regulations were to be imposed which would be onerous and degrading to the medical profession, or if the law were misconstrued or misapplied in some way that would have that result.

Do you not think Congress could reasonably be counted upon to protect the medical profession from degradation and to protect the people from that sort of distortion of the law?

Dr. GOIN. So one might think the same thing of the House of Commons.

Senator PEPPER. It is always difficult, of course, to make a comparison with another country, and we get different advice as to how the system is working in England. I suppose you hear the doctors' side of it, and you no doubt have the impression that it is not working out very well. Is that your impression?

Dr. GOIN. It is, indeed.

Senator PEPPER. Suppose the plan is a failure; is it your idea that it is a failure that does more harm or good?

Dr. GOIN. Their plan?

Senator PEPPER. In England.

Dr. GOIN. It is my impression that it gives extremely poor service. It is ruining doctors and discouraging their sons from becoming doctors.

Senator PEPPER. And that is not in the public interest?

Dr. GOIN. No.

Senator PEPPER. I want to see whether or not this is a reasonable inquiry to make. In England the Labor Party is in power. It was under the Labor Party that this plan was put into effect, although I had understood that the Conservatives were in power during the war. But let's just suppose that the Labor Government is backing this; it is, is it not?

Dr. GOIN. True.

Senator PEPPER. Now, if it is contrary to the public interest, if it does more harm than good, if all these ills have developed, why would you not think that the Conservative government, the opposing party, would advocate the abolition of this system to the people?

Dr. GOIN. Yes; I would.

Senator PEPPER. Are they doing that?

Dr. GOIN. Perhaps it is the economy of the United States.

Senator PEPPER. I am not asking you that. I am asking you whether or not you have any information that the Conservative government, headed by Mr. Winston Churchill, is telling people that they oppose this plan?

Dr. GOIN. On the contrary, I am informed that someone made a statement that they would not.

Senator PEPPER. That they would not abolish it?

Dr. GOIN. Yes.

Senator PEPPER. Now, is it not strange that one of the political parties, the one desiring power, would seek to abolish it?

Dr. GOIN. I would not think so.

Senator PEPPER. You do not deny in England that the people there still freely elect their officials, do you, and that free speech and freedom of the press still exist?

Dr. GOIN. No; I think that is true.

Senator PEPPER. In other words, it undoubtedly has many vices, but at least it does have some persuasiveness that it was adopted in a country that has a free ballot. It has been in effect over 6 months, and the opposing party is not promising the people that they will abolish it if they come in power.

Dr. GOIN. It may have been very popular with the people. Of course, one could speculate about that when we remember that you have a very distinct class system which you do not have in this country, with the result that the so-called lower class, which comprises most labor in England, until they had compulsory health insurance did not have the medical care at all. The average worker was quite satisfied to go to the drug store and get a bottle of medicine when he was sick. When he had a sore tooth he had it pulled out, so that the majority of these people at the age of 26 had no teeth at all. But our people are not that way and never were that way.

Senator PEPPER. Just one other reference to England. I heard recently from a Labor member of the House of Commons and a Labor member of the House of Lords and from a Conservative of the House of Commons who is not at all in sympathy with the labor program—I heard all three of those men when they were visiting in Washington within a period of 10 days say, in effect, that the strongest appeal to the middle class—conservative, shopkeeping, professional class—of people was the existence of this health plan which the British Government now has in effect. Those middle-class, professional, shopkeeping people voted for the Labor candidate because they thought he was strongly behind this proposal.

Senator TAFT. You do not suggest that as a mandate to this Congress, do you, Senator, in the next election?

Senator PEPPER. I do not know if we would have similar experience if we had it in effect in this country; I would be willing to go to the people on the issue of whether or not it should be continued, if we could have an experiment with it.

Dr. GOIN. Maybe we are confusing political value with medical value in this. I am not disputing political value.

Senator PEPPER. The last thing, Doctor, you take the point of view here that this legislation that some of us are sponsoring carries with it an implication or a connotation that our medical care is not good and that our present system is bad in comparison with the systems of other countries.

May I put it this way, and ask if this is not a positive approach to the subject? Of course, American medical care is the best in the world. But the question is, Is it as good as it could be in America?

Dr. GOIN. No; I think not.

Senator PEPPER. Probably the American citizen is the best-housed citizen in the world. Housing is probably better in America than any other part of the world, but the question is, Is it as good as we can make it in America?

We have in the Senate here a big housing program to take more people out of slums and to get housing opportunities for more of our people, and I dare say we will continue that. We probably have the best school system in the world, certainly one of the best, yet we have just appropriated $300,000,000 from the Federal Government to help make it better.

It is a question of whether or not we are doing all that could be done in this country.

Dr. GOIN. I will agree with you completely that we need to further our system of medical care. I do think we have a problem of medical care, but I do not think this is the way to solve it.

Some people have made the statement that our system is archaic or obsolete, and I do not like that, but I do not think this is the way to solve our problem.

Senator PEPPER. I just want to say this, Doctor; I have never made the statement that our system was archaic or obsolete. I do think that public opinion is generally coming around to the conclusion that we can no longer rely upon the old system of paying for it; that is, the patients simply paying all the doctor's fees or the hospital bills when illness comes.

I think your American Medical Association advocates the voluntary principle which is used today, and some of us think that even the voluntary system will not be adequate as a means of making it possible for the masses of America's people to pay for the kind of medical and hospital care they require.

That is all I have to say. Perhaps Senator Taft or Senator Donnell will have some questions.

Dr. GOIN. Would you care to have this letter, Senator?

Senator PEPPER. Yes.

(The letter referred to is as follows:)

HEALTH SERVICE SYSTEM,
San Francisco, Calif., May 28, 1947.

MY DEAR DOCTOR: A little over 2 years ago I found it necessary to write a letter to all the doctors serving the members of our system, appealing to them to order fewer laboratory tests and X-ray examinations, and to endeavor to keep from hospitalizing patients who could be treated at the office or in the patient's home. The results following this appeal were good. Our system received for some time more helpful cooperation from the doctors.

I must again make an earnest, hopeful appeal that you will again begin to cooperate with the Health Service System and aid the medical director to maintain the unit at the dollar value. This has been done during the last 4 years.

It came as a surprise and a disappointment, no doubt, that last month the Health Service System had slipped back a little, and the unit of which we were so proud paid only 91 cents.

This was a surprise also to the board of directors of the Health Service System, and it was a surprise to myself as medical director when I found that the February bills were so high the unit had to be depreciated.

This fault is not with the board of directors of our system or the administration, and I can plead that it is not with the medical director. In my opinion, after many months of observing the great increase in all our services, this fall in the value of the unit rests primarily with the doctors themselves and secondarily with our Health Service System members.

This letter, therefore, is an attempt to explain to you just how this came about, and a similar letter will go out to all our members to show how they have contributed by their thoughtlessness in needlessly adding to the system's expense.

Let me place before you some figures so that you may realize the manner in which our bills have stepped up:

An increase in total medical expense for February 1947 over the same month of the previous year is 36 percent.

During the same period the increase in membership was 6 percent.

The increase in the number of units of doctor services was 38 percent.

Office calls for February 1947 increased 20 percent over the same month of 1946.

Hospital expense was 87 percent higher than for February 1946. This is due to substantial increases both in total days of hospitalization used and in the cost per patient-day while in the hospital.

X-ray cost for ambulatory patients has increased 65 percent in March 1947 over March 1946.

Increase in clinical laboratory expense for ambulatory patients was 34 percent in March 1947 over March 1946.

During this period there has been no endemic of disease in the city and no unusual epidemic of any disease. The membership in the Health Service System has not increased perceptibly during the year.

The Health Service System members have contributed to this great increase by demanding too much medical service. People in general have more knowledge now on medical subjects gained from magazines, public lectures, and from over the radio; also from quack advertisements in the newspapers. Much of the so-called medical knowledge gained in this way has given them a mass of false information. It has brought about many unnecessary visits to the doctor to get treatment for trivial things. Such minor ailments as could be treated as well by their home remedies as by the doctor. Such needless calls take up the doctor's time and add a great expense for the system.

I appeal to the physician to give our system his help in this matter. It can be done by explaining to the patient that he should not apply for treatment for such minor ailments and that it will not be necessary for him to return for treatment for this simple thing.

The members themselves as well as the doctors are to blame for the no doubt thoughtless increased cost of clinical laboratory and X-ray expense. The people in general know little about the results that can be obtained from the help of the laboratory tests or the X-ray examinations. Please, Doctor, turn such requests aside; explain to them that when needed you will have the examination made.

In this regard I now make an earnest appeal to the doctors to limit their laboratory tests and X-ray examinations to just what is necessary to make a diagnosis. It would seem that any physician, after taking a short history of his patient's case and making a routine examination in his office or in the home, will find that he can make a diagnosis without leaning so much upon the laboratories and the X-ray departments. In making a survey of the results of several hundred such examinations, particularly as regards the X-ray, because I have in the histories the reports from the X-ray laboratories, I feel safe in saying that between 50 and 60 percent of them are unnecessary. The survey of the G-I series and the barium enema examinations revealed that these were negative in nearly 75 percent of the cases.

This request also applies to the patients you have in the hospitals. It is true that some laboratory work must be done to comply with the hospital rules, but it should not be necessary to order the many laboratory tests or X-ray examinations that would contribute nothing to the diagnosis and add greatly to the expense of our hospital bills.

Every patient in the hospital is costing the Health Service System over $13 a day. The average ward rate is $9 a day, but when the patient is in the hospital our system pays all the laboratory and X-ray charges as well as for the use of the operating room and the anesthetist's fee. Within the last few months we have had an average of 31 patients a day in the hospitals. This has made our hospital bills excessive in the extreme. It is all very well for municipal hospitals and for university hospitals which are teaching schools, gathering statistics for the records, to make such thorough physical examinations of their patients, filling many pages of histories with the physical findings and laboratory tests for the benefit of their students and the records of the college. The members of the Health Service System, except in a few obscure cases, do not need any such extensive work.

May I at this time call to your attention that a few weeks ago, by invitation from the county medical society, Dr. Alvarez, a former professor at the Stanford University and since then the leading authority in medicine at Mayo Clinic, delivered an address before a big audience of doctors in which he stated most emphatically that it was waste of time and money in a great majority of cases to make complete routine examinations on the patients at Mayo Clinic, filling the records with a mass of reports, laboratory tests, X-ray examinations. Most of the laboratory and X-ray tests in all but a few cases were unnecessary except to fill the records.

Just the other day there was a statement from Dr. William J. Kerr, of the University of California in a recent medical journal to the effect that the X-ray and electrocardiogram examinations for heart cases were unnecessary. A good history and physical examination would give more information of the patient's condition than could be given by a laboratory.

Within the last 6 months doctors have gotten into the habit of hospitalizing Health Service System members for conditions that could be treated in the office or in the home. This is wrong and puts our system to an outstanding unnecessary expense. Sending patients to the hospital under benefits of the Health Service System must have the permission of the medical director. In many instances this is not being done. The first notification we receive is a notice from the hospital the next day of the patient's admittance.

Hereafter no patient, except in an emergency case, will be entitled to hospital benefits under Health Service System coverage until authorization has been given by the medical director.

The so-called diagnostic study of problem cases has always been one of contention. For this service our system pays 15 units, and allows the regular fee of $10 for necessary laboratory tests and $15 for required X-ray examination if the patient is open for these benefits. Permission must be requested of the medical director to make this study. Such requests are being made far too frequently in the last few months. I have reviewed the histories the doctors have submitted on many such cases and have given special attention to the summing up of the conclusions that the internists have made and it is my opinion that very few such cases are problem cases requiring such a study and such an expense.

The question, then, is, what is a problem case requiring such a work-up? The answer can be given in the doctor's own definition, as stated in the fee schedule of the C. P. S.:

"Complete history and physical examination on authorization of the medical director and only in cases with obscure diagnostic problems."

Sending patients to the hospital to make a diagnostic study is against the rules of the Health Service System, but recently this is frequently being done and without authorization. It is true that the patients may be in the hospital only 3 or 4 days but during that time they have been given all the X-ray and laboratory tests that the hospitals have to offer and these at the expense of the Health Service System. This cannot continue except in certain special cases and on authorization of the medical director.

Without the help of the Health Service System the city employee, and for that matter any salaried employee in the comparable average salary bracket, could not pay the present-day hospital bills, medical services or particularly the surgical fees that are charged by physicians to their private patients, especially the surgeon's fee for major operations.

Without the aid of the Health Service System the average worker would have to get along without operations of election. He would bear with the inconvenience of his ailment and, except in the case of emergencies, would not be hospitalized or operated on. The Health Service System, therefore, gives the doctors a wider range of practice. They are getting patients that they otherwise would never have, and the surgeons are performing operations which otherwise would never be done. This may compensate somewhat for a fee schedule below that of private practice.

One of the objections raised against the Health Service System by a few members of the county medical society is that it is a compulsory system. We are a dual system, a compulsory system for the city employees and a voluntary system for their dependents. A compulsory system for adequate medical coverage is a condition of employment for city employees.

Before the Health Service System was organized a questionnaire was submitted to the city employees explaining the different health systems that were operating throughout the country. Our compulsory system was then voted for by a large majority of the city employees and it was accepted by the board of supervisors, placed on the ballot as an amendment to the charter and passed by a large majority of the voters of the city. We find, therefore, that our compulsory system was a system voted for by the employees and it was the system wanted and the system voted for by the people.

In closing this long letter, may I ask your kind indulgence to accept it in the spirit of cooperation and friendship in which it was written.

We have been working together for the success of the Health Service System for nearly 6 years. You have given the best in medical practice to relieve sickness when it has occurred among our members. You have given much, cured many and have given relief to all.

The Health Service members are not forgetful. They like their doctor, and I feel safe in saying the doctors like the members of the system.

Let us hope that this good work will go on. Much has been done; there is more to do.

I am ambitious, as the medical director of this system, that with your help we will make it the most outstanding health service system in the country. Many leading public health officials have so acclaimed.

This temporary drop in the value of our unit will not last more than 2 or 3 months. I can promise you, and our board of directors can promise you, that with your professional help it will never occur again.

Sincerely yours,

A. S. Keenan, M. D.,
Medical Director.

Senator Donnell. At the outset of your statement, without stating the particular bill, you say: "I am in complete opposition to this legislation." I take it what you are referring to is S. 1679; you are not referring to S. 1581?

Dr. Goin. No, I interpolated that when I made the statement.

Senator Donnell. Now, Doctor, Senator Pepper, I think, very skillfully, took you over a line of examination here this afternoon on an item that would be regarded by him as unusually important; that is, on the question as to whether you are willing to make a little harmless trade with him on the use of epithets; that is to say, if you did not call him something, he would not call you something; that you would not call this socialized medicine.

Now, doctor, I want to ask you whether or not you believe this to be true: as you say in your statement here:

> I oppose it as an American because I am persuaded that this type of legislation is one of the final steps on the road to state socialism.

Is that your belief?

Dr. Goin. I do believe it.

Senator Donnell. Then I take it, Doctor, that you do regard this particular legislation as properly called socialized medicine; am I right on that?

Dr. Goin. Well, that is the way it seems to me.

Senator Donnell. And that is the fact, Doctor, that it is so called and so termed from one end of this country to the other; is that not a fact?

Dr. Goin. I think that is the general name applied.

Senator Donnell. I would like to examine into that. I think it is very important that any inference from this afternoon—when you very skillfully guided your attention to this trade, very harmless in its nature—I think it should be perfectly clear in this record what you really believe and also what the record actually shows.

I have before me a copy of this 1679. Doctor, I would like to call your attention to a few things, as bearing on whether or not your conclusion is that this type of legislation is one of the final steps on the road to state socialism.

On page 103, I call your attention to title 7:

> The Congress hereby declares that it is the policy of the United States to take such steps and to utilize such of its resources as are necessary toward making adequate health services available to all our people regardless of residence, race, creed, color, or economic status.

I ask you, doctor, if you do not agree with me that is a clear, definite statement of the fact that Congress declares that it is the policy of the United States to use the governmental resources—its resources, the resources of the United States—in making available these health services; is that correct?

Dr. GOIN. It could not mean anything else.

Senator DONNELL. So we start out then with a situation that does not exist today, namely, that in this bill 1679 shall be incorporated—that it is the policy of the United States to utilize the resources of the United States; that is to say, that the United States Government and its people will take these steps that I have described.

Now, I will ask you if that is one of the things that leads you to think that this type of legislation, according to your statement, is one of the final steps on the road to state socialism?

Dr. GOIN. Yes, it is.

Senator DONNELL. Without taking you down through all this great maze of provisions, here is what occurs thereafter. On page 104 it starts out:

> The personal health services to be made available as benefits to eligible individuals as provided in this part are medical services, dental services—

under the terms of this bill, a governmental bill: that is correct, is it not?

Dr. GOIN. Yes.

Senator DONNELL. Then I pass on down to lines 10 and 11 in reference to the persons who shall provide each respective class of service who are noted as:

> who are qualified under part C of this title, to do so.

That indicates, does it not, that a law is entering into this in determining who shall be qualified to provide these services which are determined and defined to be benefits under this law of the United States?

Dr. GOIN. True.

Senator DONNELL. Is not that a further indication as to whether or not this is on the road to state socialism; would you not so agree?

Dr. GOIN. I have no doubt of it.

Senator DONNELL. Now, doctor, look on the next page, if you will, on the lines 13 and 14, the subject there under discussion in hospital services.

> Hospital services consist of hospitalization, including necessary nursing services, and such physician, laboratory, ambulance, and other services in connection with hospitalization as the National Health Insurance Bord, after consultation with the National Advisory Medical Policy Council, by regulation designates as essential to good hospital care.

Those are two governmental boards; a board and a council created by this bill; are they not?

Dr. GOIN. That is a point I tried to make. The language of the law is fairly gentle, but it is perfectly possible for the Board to make any or almost any additional law that it so wishes.

Senator DONNELL. I just want to point out a few indications as to whether or not this is a governmental division, whether you call it insurance or what it is to be called, that it is something under the Government, to be administered by the Government, to be paid for by taxes secured by the Government, and under regulations under governmental boards.

This board and council to which reference is made on page 105 is a board and council, respectively, created by this bill; are they not?

Dr. GOIN. Certainly.

Senator DONNELL. And the regulation referred to on pages 103 and 104 is a governmental regulation; is it not?

Dr. GOIN. Regulation of the Board.

Senator DONNELL. And it is a governmental board—the National Health Insurance Board?

Dr. GOIN. Yes.

Senator DONNELL. That is correct; is it not?

Dr. GOIN. Certainly.

Senator DONNELL. Now, while we are on that subject, I wonder if you would be kind enough to turn to page 136 of this bill and make just a little inspection here for a moment of what this National Health Insurance Board is.

In the first place, down at the bottom of the page 136, does it not read:

> There is hereby established in the Federal Security Agency a National Health Insurance Board—

You see that; do you not?

Dr. GOIN. Yes.

Senator DONNELL. Mr. Oscar Ewing is to be the head?

Dr. GOIN. Yes.

Senator DONNELL. As the governmental Security Administrator?

Senator PEPPER. I have to be absent for a few minutes. If you will proceed with the examination, I will be back in just a few minutes.

Senator DONNELL. Yes.

Now, this Board is to be composed of five members, three of whom are to be appointed by the President and the other two of whom shall be the Surgeon General of the Public Health Service and the Commissioner for Social Security.

Dr. GOIN. That would be the other two appointed by the President already.

Senator DONNELL. The Surgeon General and the Commissioner for Social Security, yes, of course. Then there are five appointees by the President. I would assume the Surgeon General and the Commissioner of Social Security are appointed by him; I have never heard anything to the contrary as far as I can recall.

Now, if you will proceed to the middle of the page, you will notice in lines 11 and 12 that "each appointed members shall receive a salary at the rate of $12,000 a year" with certain exception, for a term of 6 years. I should say, with certain exceptions, that is the provision; is it not?

Dr. GOIN. Yes.

Senator DONNELL. They are also forbidden to do anything else.

Dr. GOIN. Yes.

Senator DONNELL (reading):

> During his term of membership on the Board, no appointed member shall engage in any other business, vocation, or employment—

so that Board that is going to issue this regulation is to be a functioning governmental board; it is not?

Dr. GOIN. Surely, full-time.

Senator DONNELL. Am I correct in assuming that is one of the elements which enters into whether or not this type of legislation is a step toward state socialism?

Dr. GOIN. It certainly seems so to me.

Senator DONNELL. Now, if you will drop down to the bottom of page 137, Doctor, I want to call your attention to this. Now, you know this, of course, but I think it is just as well to put in the record at this point. Here we have a board, with power to make regulations, as specified on page 105, each member of which is to get $12,000 a year, and let us see what power that board has.

On page 137, if you will be kind enough to just refer to that with me—

> all functions of the Board shall be administered by the Board—

and then what are the next words?—

> Under the direction and supervision of the Federal Security Administrator—

That is the way it reads: is it not, Doctor?

Dr. GOIN. That is correct.

Senator DONNELL. So we have a Board here, a governmental Board, paid good-sized salaries. All of these functions, which we read 32 pages ahead, are administered under the direction and supervision of the Director.

Dr. GOIN. Frankly, when I read it I thought it seemed to me that the functions remaining with the Board were to do what the Administrator of the Federal Security Agency told them to do.

Senator DONNELL. I do not think your conclusion is at all unusual and strange. At any rate, the language is as I read it from the bill, that all functions of the Board—not part of them but all of them—shall be administered by the Board under the direction and supervision of the Federal Security Administrator. That was what it said; it is not?

Dr. GOIN. Certainly.

Senator DONNELL. Then it provides down here in its duties what it can do. In the first place it performs such—

> functions as it finds necessary to carry out the provisions of this title, and shall make all regulations and standards specifically authorized to be made in this title.

You recognize those words, "regulations and standards"? It is going to have to make standards and regulations and such other regulations not inconsistent with this title as may be necessary. It again begins back 30 pages; it begins on page 103.

Dr. GOIN. Yes.

Senator DONNELL. And then we read a little further on page 138:

> The Board may delegate to any of its members, officers, or employees, or with the approval of the Administrator to any other officer or employee of the Federal Security Agency, such of its powers or duties, except that of making regulations, as it may consider necessary and proper to carry out the provisions of this title.

Am I not correct in this analysis that way back on page 105 is the power of making regulations, the duty of making regulations, vested in this Board, after the consultation with the Council—the Advisory Council—all simmers down to the fact that all that making of regulations in the first place is to be done by a governmental organization, but is to be done under the direction and supervision of one individual, the Federal Security Administrator; am I correct in that analysis?

Dr. GOIN. It would seem to me that would be the right——

Senator DONNELL. And not only that regulation but all these regulations that are specified on page 138; namely, all regulations and standards specifically authorized to be made in this title, and such other regulations not inconsistent with this title as may be necessary, so I take it, Doctor, that the power of regulations there is twofold: (1), to make those it says you will and the others that he is told you cannot make; is that it?

Dr. GOIN. Yes.

Senator DONNELL. And that his whole power is subordinated to the one United States governmental official, namely, the Federal Security Administrator; that is correct, is it not?

Dr. GOIN. That is correct.

Senator DONNELL. Do you know if the Administrator shall ever have had any experience with the practice of medicine or health matters?

Dr. GOIN. Nothing in here says so.

Senator DONNELL. He is not a doctor, is he?

Dr. GOIN. He is a lawyer.

Senator DONNELL. Mr. Ewing came from New York City and is a lawyer.

Dr. GOIN. That is my understanding.

Senator DONNELL. Now, I do not want to unduly burden the record here but we are talking about whether or not the Government is going to take part in this thing or whether it is just this term "socialized medicine."

I want to point out something that might be drawn here from this earlier testimony which should be clearly negative because you have stated, and I understand you believe, that this type of legislation is one of the final steps on the road to state socialism. That is correct, I believe; is it not?

Dr. GOIN. Yes.

Senator DONNELL. Now, doctor, if you will turn over to page 106 and 107 of the bill, there we find a list of the availability of benefits.

If you will just turn over now on page 107, line 13, we will read a little more about what this Board does:

> The Board shall have the duty of studying and making recommendations as to needed services and facilities for the care of the chronic sick afflicted with physical ailments, and for the care of individuals afflicted with mental or nervous diseases, and as to needed provisions for the prevention of chronic physical diseases and of mental or nervous diseases; and of making reports from time to time, with recommendations as to legislation, but the first such report shall be made not later than two years after benefits under this title first become available.

Doctor, do you not consider or would you not consider, I should say, that a Board that has the power of studying and making recommendations as to the services for the care of the chronic sick and of the provisions for the prevention of chronic sickness, and doing all this under the supervision and direction of the Federal Security Administrator, would you not consider that under all those circumstances, with the powers of making regulations that are prescribed here, all dovetailing back up there to the Federal Security Administrator, would you not consider that there is ample and good reason to say that this is a strong step, a long step in the direction of state socialism?

Dr. GOIN. I think it is, and I think it makes the Federal Security Administrator the director of medical care in America.

Senator DONNELL. It looks to me like there is a good deal of merit in that statement.

Now, Doctor, we would be here all day long and all week if we took up every provision here, but let us just turn over, if you will, please, to page 112.

You will note down at the bottom of the page, lines 22 and following:

> The Board—

that is the same creature, the Board which is under the direction of the Federal Security Administrator—

> after consultation with the Advisory Council, shall establish standards as to the special skills and experience required to qualify an individual to render each such class of specialist services as benefits under this title, and to receive compensation for such specialist services. In establishing such standards and in determining whether individuals qualify thereunder, standards and certifications developed by professional agencies shall be utilized as far as is consistent with the purposes of this title, and regard shall be had for the varying needs and the available resources in professional personnel of the States and of local health-service areas.

You observe that that is a very important provision, is it not, Doctor, that the Board, acting under the direction and supervision of the Federal Security Administrator, who is not a doctor and does not have to be a doctor, shall establish standards as to the special skills and experience required—

> to qualify an individual to render such class of specialist services as benefits under this title.

That is a pretty important, all-embracing power.

Dr. GOIN. It frightened me personally considerably when I read it because I have gone to the trouble of getting myself certificated by a professional examining board, and now Mr. Ewing, who does not, I imagine, take a very favorable view of me anyway, could easily uncertificate me.

Senator DONNELL. Well, at any rate, it is a rather curious thing, Doctor, that not only is this a governmental scheme that is worked out, to be administered by governmental officials, but a man who does not have to have studied medicine 5 minutes in his life has the power to direct a Board as to the standards with respect to which the Board fixes as to special skills and experience required to qualify an individual to render specialist services.

That is a pretty comprehensive power, to say the least, is it not?

Dr. GOIN. I would think it is extraordinarily so.

Senator DONNELL. Very extraordinary.

Now, Doctor, would you turn to page 116—I seem to have passed that by, although I have it marked here—would you just note down there in line 16, where it says:

"Each agreement made under this part"—now, that part is Part C, which is "Participation of Physicians, Dentists, Nurses, Hospitals, and Others", and I call your attention to the fact, Doctor, that among the agreements that are to be made under this part are the agreements set forth over here on page 118. Those are agreements for the furnishing of medical or dental services, other than specialist services, as benefits under this title, shall provide for payment—and then it tells the methods of payment; that is among the agreements that are in this title.

Then, we go on down the list here. Here is an agreement for the furnishing of specialist services, and the agreements for the furnishing of hospital services, and so forth and so on, and with a provision down here on the agreement of furnishing hospital services that the Board—the same Board that is under the direction of the Administrator—after consultation with the Advisory Council and—

> with representatives of interested hospital organizations, may by regulation prescribe maximum rates for hospitalization furnished as benefits under this title—

and so forth.

Well, going back down to page 112, you observe there——

Dr. Goin. Could I comment on that section?

Senator Donnell. Yes; I would be glad if you would.

Dr. Goin. You know if I were interested in setting up a truly socialistic system, that I could control, and if I were a Social Security Administrator, I would fix the rates so low that the hospitals could not operate, and common sense and humanity would say that I would have to operate them.

Senator Donnell. Well, there is no insurance against such a plan being worked out under this bill, is there?

Dr. Goin. There is not.

Senator Donnell. No, sir.

Let us go back to 112—I mean, go back to page 116 at line 16. That states:

> Each agreement made under this part—

that is, all these agreements that I have mentioned, and I have no doubt there are others—here is an agreement on page 120, agreements for furnishing of home-nursing services or auxiliary services; down here there is a provision about the amount of payments for services—that is on pages 120 and 121; all sorts of things are in here about the rates, and amounts of payments, and the assurance of—

> reasonable equivalent awards for practitioners selecting different methods of payment, in consideration of the value of the services they render.

There is contained a provision with respect to the maximum limits upon the number of eligible individuals with respect to whom any person may undertake to render services—I am coming to that in a minute—all of these things on page 116—

> shall specify the class or classes of services to be furnished or provided pursuant to its terms, shall contain an undertaking—

and I want to call your attention to this—

> contain an undertaking—

lines 19 and 20—

> to comply with this title and with regulations prescribed thereunder.

Now, Doctor, do you agree with me that that says in effect that anybody who makes any of these agreements that I have described—and maybe there are others that I have overlooked, probably a lot of others that I have overlooked, maybe not, but I do not pretend to have found them all—does that not say, and is it not reasonable in my understanding that every one of those agreements shall contain, and I quote from line 19 and following—"an undertaking to comply with this title and with regulations prescribed thereunder," so that that would be right into the contract, would it not, that everybody who makes one of those contracts for any of these things agrees to comply with the regulations prescribed under this title? That is correct, is it not?

Dr. GOIN. You just have to sign a blank check.

Senator DONNELL. I beg pardon?

Dr. GOIN. You just have to sign a blank check.

Senator DONNELL. You sign up to comply with whatever this Board that acts under the direction, and I emphasize the word "direction" again, of the Federal Security Administrator and what he shall prescribe; that is what it says, in substance.

Dr. GOIN. I am afraid there could not be any doubt about it.

Senator DONNELL. Now, Doctor, let us just take a glance here at one or two other things.

I spoke about this, at the bottom of page 121, section (c), where it says:

> Maximum limits upon the number of eligible individuals with respect to whom any person may undertake to render services in any local health-service area may be fixed by the local administrative committee or local administrative officer of that health-service area only on the basis of a recommendation of the professional committee in that area that such limitation is necessary to maintain high standards in the quality of medical, dental, or other services furnished as benefits. Any such limits shall take account of professional needs and practices and shall provide suitable exceptions for emergency and temporary situations.

Now, Doctor, you will observe there that it speaks about local administrative committees. Perhaps we will come back to that; that is over here in part D that we are coming to in a minute. We may consider that a little further.

The point I am directing your attention to at this moment is that this prescribes here, does it not, quoting from the bottom of page 121, "Maximum limits upon the number of eligible individuals" may be prescribed, so that a doctor cannot take more than a certain number of persons, the maximum number of which shall have been prescribed by this local administrative committee or local administrative officer. That is correct, is it not?

Dr. GOIN. Yes; that is one of the indications that the real intention is to function on a capitation basis.

Senator DONNELL. Capitation basis?

Dr. GOIN. If you must have a maximum, you must have a capitation basis and a capitation panel.

Senator DONNELL. Now, we have had similar testimony on similar bills before, but take a case like this. Suppose you lived in Springfield, Ill., and Dr. Smith was the most popular man, the most popular doctor in Springfield, and they decide there in Springfield to follow this capitation plan, follow the regulations, and decided to do that, and Dr. Smith is allowed 1,000 patients.

He can take 1,000 patients, and there is a great rush down to the post office on the day that the selection is to be made, and bulletin boards are there; everybody wants to take Dr. Smith and they can pick him, and there is a rush for Dr. Smith, and a thousand people take him right quickly.

Then, Dr. Lawrence, over there has been out of town for a few days, and we will say that he has been living there in that town, and he wanted Dr. Smith, too. Well, he is too late, and he has got to take somebody else, has he not, unless there is some special provision made in this bill for Dr. Smith to have some elasticity in this list, is that right?

Dr. GOIN That is right.

Senator DONNELL. Now, suppose that you had made this selection. In the first place, that makes it impossible for Dr. Smith to take on a dozen of us who happen to be out of town that day and cannot get in to make our selections; that is true, is it not?

Dr. GOIN. That is true.

Senator DONNELL. Now, suppose that after this selection has been made, and we will say I have selected Dr. Smith—I thought he was the very man, but suppose I am stricken with heart disease 3 years after that, or make it 1 year after that, and I think that Dr. Jones ought to have been the man whom I selected, but I look over there and lo and behold Dr. Jones' panel is full. Is there any hardship there that you see which is going to be inflicted on me?

Dr. GOIN. I should think it is a very great one. You do not have a free choice of physicians at all, and furthermore if Dr. Jones' panel was not fully filled, you might find very great difficulty in transferring yourself from one panel to another. It can be done, but there would be some difficulty.

Senator DONNELL. In other words, you have to go through the forms and regulations, and whatever is prescribed here in order to get it done, is that not what is done here?

Dr. GOIN. Yes, certainly.

Senator DONNELL. Doctor, if you will be kind enough now to turn to—well, let us try page 143. It says:

> The Federal Security Administrator, through such units of the Federal Security Agency as he may determine, shall upon his own initiative or upon application of any individual make determinations as to the eligibility of individuals for benefits under this title.

In other words, is it your understanding, am I correct in my understanding, that that gives the Federal Security Administration the right to make a decision as to whether I am entitled—whether I am eligible for benefits under the title? Is not that what it says?

Dr. GOIN. If it means what the English language says, that is what it means.

Senator DONNELL. Yes.

Then, there is some provision here about getting the man on appeal up, is it, through the court, or—where is it here that you can go on up with it? I do not have all of this before me, but here are provisions about impartial tribunals to afford hearings, which finally winds up in the courts somewhere. At any rate, in order to upset a decision made by the Federal Security Administrator down here in Washington, and acting through such unit of the Federal Security Agency as he may determine, you have got to comply with whatever regulations have been prescribed by this Board which the Federal Security Administrator himself directs. That is correct, is it not?

Dr. GOIN. It would seem so.

Senator DONNELL. Yes, sir.

Now, Doctor, I was about to get away from this matter of the local administration—let me see where that was again—where is that, Mr. Sneed? Here it is, back on page 123. Have you read that, Doctor, with care, the provision about the local administrative committees and so forth?

Dr. GOIN. I have, but I must confess that it baffles me.

Senator DONNELL. I beg pardon?

Dr. GOIN. I say, I have read it with care, but I must confess that it baffles me.

Senator DONNELL. Well, I do not think this afternoon that I am prepared to examine you on this either; I have not gone through that, and I can see that there is a provision here for decentralization of administration, and local professional committees and methods of administration, and in due time we will certainly examine that with much care.

Dr. GOIN. Except, as nearly as I can tell, Senator, when I did read it, and then referred back to the section which you read, and which authorized the Federal Security Administrator to direct the Board, it seems to me that all of these regulations are more decorative than anything else, and in the final analysis the Federal Security Administrator makes the regulations, and that is the end of it.

Senator DONNELL. I think you are right. If you will turn over to the bottom of page 129, which Mr. Sneed has just called to my attention—I have read it before—it says this:

> In exercising their functions and discharging their responsibilities under this title—

now, that is this great long title we started way back here on page 103, Prepaid Personal Health Insurance Benefits—

> In exercising their functions and discharging their responsibilities under this title local administrative officers and communities, local advisory committees, and local professional committees shall observe the provisions of this title, and of regulations prescribed thereunder, and of any regulations, standards, and procedures prescribed by the State agency.

So, every one of these committees has got to observe two sets of regulations: One, those that are prescribed by the State agencies, and the other, those that are prescribed by the Board, which in turn is under the direction, to quote the language here in the bill earlier, of the Social Security Administrator. That is correct, is it not?

Dr. GOIN. It frankly did not seem to me that they had very much authority.

Senator DONNELL. Yes. Now, Doctor, would you turn, please, to page 134—yes, here is a provision on 134 that I want to call to your attention, beginning with line 13. That is a provision, as you will note, which is as follows:

> If a State has not prior to July 1, 1950, submitted and had approved a plan of operations, the Board shall notify the governor of the State that the Board will be required to administer this title in the State, commencing July 1, 1951.

You notice that, do you not?

Dr. GOIN. Yes. The State does not have any choice at all.

Senator DONNELL. That is the Federal Board.

Dr. GOIN. The State seems to have no choice at all.

Senator DONNELL. In other words, the State has to submit a plan of operations. Now, if it has not done it by July 1, 1950, then the

Board, this Federal Board which is under the direction of Mr. Ewing, in his official capacity, notifies the Governor that the Board will be required to administer the title in the State, commencing July 1, 1951.

Dr. Goin. Senator, if I could call your attention to this, it is slightly worse than that. The State has to not only submit the plan, but to have had it approved by the Board. In other words, if the Board, does not like the plan the Board can then go in and operate its own plant.

Senator Donnell. Yes; I think you are right. I am glad you called my attention to it. If the State has not prior to July 1, 1950, had approved a plan of operation—in other words, that is right. Unless the Board has itself decided in its wisdom, has put into its head, perhaps, by the director, the Federal Security Administrator, who has this power of direction, if it has not approved the plan of operations by July 1, 1950, then the Board, which has not approved, can take charge and go ahead in the State; that is right, is it not?

Dr. Goin. That is right; that is the way it seems to me.

Senator Donnell. This is a provision which should be incorporated in the record at this point because there is one provision further, and that is that the Board shall—

> provide for the publication of such notice—

that is, a notice to the governor—

> in at least two newspapers of general circulation in the State. If within 60 days after such notification to the governor the State has not submitted an approvable plan, the Board shall undertake the administration of this title in the State commencing July 1, 1951, and shall continue such administration until one year after the one year after the submission and approval of a plan of operations in accordance with this section: *Provided*, That the Board may waive the requirement that a State plan must be submitted and approved one year prior to commencement of State administration if it is satisfied in a particular case that the substitution of a shorter preparatory period will not prejudice the interests of eligible individuals in the State.

Now, Dr. Goin, would you turn, please, over to the bottom of page 145. I was talking about these appeals of one kind or another. Starting on page 144, at the bottom of the page, is a heading, "Complaints of eligible individuals and of persons furnishing benefits." There it tells anybody, if he is aggrieved, let us say, what he can do. Let us see what he does here. He may make a complaint to the local administrative officer or the local executive officer, that is, the fellow who is required to follow both the rules prescribed by the State and the rules prescribed by the Board, which, in turn, are subject to the administration of the Federal Security Administrator.

Here you are on your back with typhoid fever, and you do not like what is happening, and you have the privilege of making this complaint to this official, do you not, here on page 145?

Dr. Goin. Yes; that is true.

Senator Donnell. If that officer to whom you have made that complaint finds, after investigation—now, he has got the right to investigate; there is nothing prescribed there as to how long that investigation is required to be or how short it must be, is there?

Dr. Goin. As a matter of fact, he does not have to do anything at all if he does not think it is well founded.

Senator Donnell. Well, it says if the officer to whom such complaint is made finds, after investigation, that the complaint is well founded, he shall promptly take such steps as may be necessary and appropriate to correct the action or inaction complained of; and he shall notify the individual or other person making the complaint of his disposition thereof.

All right, now, suppose you are lying there sick, and he decides against you, and you think something ought to be done that is not done, and he investigates it, and you are getting sicker all the time, and he decides against you, but you have your rights all right. They are protected here in the next line.

Here you are now, you are suffering, and this says:

> Any such individual or other person dissatisfied—

you may not be conscious enough to know whether you were dissatisfied, but supposing you were. What do you do? You have got to do it in writing; I suppose typewriting would be sufficient, but it must be in writing—

> request a hearing thereon and shall be afforded opportunity for the same pursuant to subsection (b) of this section.

All right, what does subsection (b) say?

> Provision shall be made for the establishment of necessary and sufficient impartial tribunals to afford hearings to individuals and other persons entitled thereto under subsection (a) of this section, or section 717 (d) of this title.

Well, let us turn back to 717 (d)—that is over here where the State agency finds—

> that an individual or other person under agreement to furnish or provide personal health services as benefits is no longer qualified to furnish or provide such services, or has committed a substantial breach of the agreement—

And so forth.

All right. Now, these tribunals are to be established here to afford hearings under subsection (a) of this section, or way back here in section 717 (d) of this title, and for further review of the findings, conclusions, and recommendations—

> of such tribunals, in accordance with regulations made by the Board, after consultation with the Advisory Council.

Of course, all the time the Federal Security Administrator is on top of the whole thing with his power of direction. That is right, is is not? That is right, Doctor?

Dr. GOIN. That is certainly right.

Senator DONNELL. Well, now, it goes ahead here with some further protective measures for you, who are lying there sick all the time. It says:

> With respect to any complaint involving matters or questions of professional practice or conduct—

you may have complained about the way the doctor acted toward you, his treatment.

> With respect to any complaint involving matters or questions of professional practice or conduct, the hearing body shall contain competent and disinterested professional representation; and with respect to any complaint involving only matters or questions of professional practice or conduct, the hearing body shall consist exclusively of such professional persons.

Now, do you understand, Doctor, does that mean that you are going to have a jury of doctors which is going to pass this thing? They have got to be brought in to decide on that on appeal from the action of the local official; is that right?

Dr. GOIN. I am sure that is the case.

Senator DONNELL. Let us see how much more there is. Let us go on now a little further. Over on page 147 there are other provisions, How are we going to pay for all this thing? You will notice on page 147, Doctor, that there is created on the books of the Treasury a separate account to be known as the personal health services account. Funds are to be invested by the Secretary of the Treasury. They are to be available for all expenditures, and there is going to be appropriated, way down here at the bottom of the page, first—

> sums equal to 3 per centum of all wages estimated to be received during such fiscal year.

By the way, Doctor, this does not provide anything for the fellow not getting wages, does it? The indigent is not covered, is he?

Dr. GOIN. No. Neither the indigent nor the person who has become too old to work.

Senator DONNELL. Just the fellow who is fortunate enough to have a job is covered by S. 1679.

Dr. GOIN. He has to have a job and a pay check.

Senator DONNELL. Sir?

Dr. GOIN. He has to have a job and a pay check.

Senator DONNELL. All right.

Now this is—

> sums equal to 3 per centum of all wages estimated to be received during such fiscal year;
>
> Sums equal—

in the previous subsection those are sums to be appropriated—and then—

> sums equal to the estimated cost of furnishing dental services and home-nursing services as personal health-service benefits during such fiscal year—

and then here is a rather interesting section, clause (3):

> Any further sums required to meet expenditures to carry out this title.

So, if the 3 percent is not enough—it does not tell you, by the way, where that 3 percent is to come from, does it?

Dr. GOIN. I suppose congressional appropriation; that is what it says.

Senator DONNELL. Yes, but I do not mean that; I mean it does not tell you how the Treasury is going to get 3 percent. It does not mention that that is to be a pay-roll tax.

Dr. GOIN. I do not think it is meant to be actually.

Senator DONNELL. If that were to be in the bill—not in here—if it were to be in this bill, I submit for the record that this bill then would have probably gone to the Committee on Finance for its consideration rather than to the Committee on Labor and Public Welfare, so although it tells how to spend the money and tells the amount of it in percentages here, there is nothing that tells where it comes from. That is right, is it not, in this bill, so far as you have seen it? Is that right, Doctor?

Dr. GOIN. Oh, yes, that means an appropriation from the general funds of the Treasury.

Senator DONNELL. Yes. So that we find here that for some reason the framers of this bill did not put in anything about how they were going to get this money. They have got the provision for the appropriation all right, and it is not going to be limited by the amount of 3 percent. Any further—

> sums required to meet expenditures to carry out this title—

Congress is directed here to appropriate.

Then, there is a provision which states:

> There shall be appropriated to the account in the fiscal year 1951, a sum equal to 1 percent of all wages estimated to be received during such fiscal year, to constitute on July 1, 1951, a reserve—

And so forth and so on.

Then, there is some more here with respect to allotments of funds, and all these provisions here about the funds; that is the way the thing is to be supported.

Now, Doctor, bearing all these things in mind, all this creation of boards and officials and rules and regulations and Federal Security Administrator in Washington, D. C., sitting at the top of the heap, with the power of direction over the Board that administers the whole thing, is there any doubt in your mind that that is a step in the road toward state socialism?

Dr. GOIN. I think it is one of the last steps. I think we are almost there, if we do it.

Senator DONNELL. Almost there. In fact, you would say one of the final steps to state socialism—one of the final steps on the road to state socialism, as was indicated earlier this afternoon. So, in your very courteous interchange with Senator Pepper, you are not abandoning your thought about this being a socialistic scheme nor are you abandoning your appellation of socialized medicine that was earlier mentioned, I take it? Am I right in that?

Dr. GOIN. I insist that this is a socialistic scheme; that it is one of the ultimate steps on the road to socialism, and when we have done this we will be very close to a Socialist state. I do not say that this itself constitutes socialism, but this is one of the last things that needs to be done.

Senator DONNELL. Do you think that there is any criticism to the term "socialized medicine" as applied to a scheme which is outlined in S. 1679?

Dr. GOIN. No; I do not think so.

Senator DONNELL. Now, Doctor, you were asked about England; I suppose if there was a statute passed whereby everybody was to get $5 on every Monday morning, there would be a good many people to vote for persons who wanted to run for Congress on that plank, would you not think so?

Dr. GOIN. I am quite sure that would be so.

Senator DONNELL. If they actually got it started, a good many Congressmen would be afraid to change around after it once started, is not that true?

Dr. GOIN. They would have difficulty in repealing it.

Senator DONNELL. Doctor, have you been in England yourself recently?

Dr. GOIN. No; I have not.

Senator DONNELL. Have you studied the plan over there?

Dr. GOIN. No, I could not say that I have; I have read some about it.

Senator DONNELL. You have given it some thought, however?

Dr. Goin. Yes, I have had some experience with respect to the prewar German plan.

Senator Donnell. Were you over in Germany?

Dr. Goin. Yes, sir; I spent 9 months doing graduate work at the University of Frankfurt, and observing this Krankenkasse.

Senator Donnell. Doctor, would you tell us what you would say with reference to the operation of the system they had in effect with respect to medical matters?

Dr. Goin. The first thing that impressed me was that all human dignity was gone out of it?

Senator Donnell. All human dignity?

Dr. Goin. Yes, sir; and I will give you an example. One of the teachers wanted to demonstrate something to us, and he called in a woman to be a part of the demonstration. If you were to call in a woman to be a subject of the demonstration in this country, you would have accompanying her a nurse, and you would drape her with suitable covering on the table.

There the professor said, "Susie, you get on the table and pull up your dress." She did. That seemed to me an indication that there was no human dignity. That was an everyday example and that was not an isolated example.

All of the German doctors I knew had anywhere from 40 to 60 house calls to make every day, and I leave it to you to know how much time they had to give to each individual.

They had to travel all over the city, and in addition to that they had to see 25 to 40 people in their office hours.

People came to the doctor, so they told me, for the most trivial and nonsensical things, largely to get certificates that exempted them from going to work, so that they could get their disability pay; and, of course, if a man was only working half time anyway, and the weather was bad, and he could get just about as much in staying home as going to the factory, he would obviously stay home.

I would say that was just human nature. That took up a lot of their time, and they complained about it, and they just did not have time to see people who were really sick.

Senator Donnell. Doctor, you express yourself in your statement, you say this, talking about Mr. Ewing complaining of the shortage of physicians:

> One wonders why he believes that the enactment of a law bitterly opposed by physicians (physician's sons are a substantial part of the annual crop of new physicians), and one which experience in other countries has shown to degrade physicians, could possibly increase the number of physicians.

And as you say, one wonders why he believes it could possibly increase the numbers of physicians.

Do you have any further illustration in mind as to the degradation of physicians that has occurred in other countries, or the decrease in their professional attainments or competitive desire or skill?

Dr. Goin. Well, I remind you that it was not so awfully long ago that every young man who finished medicine in America and was reasonably ambitious tried his best to go to Germany and Austria for study.

Now, everybody would give his right arm to come here. That is what has happened to their medical system. Certainly it is not as the direct result of this sort of thing, but certainly it is coincidental.

The British doctors, so I am told by British physicians, are almost reduced to a lower grade civil servant. The doctor does not have very much freedom about what he does; his time is largely taken up with writing out statistical reports and certificates to purchase corsets and false teeth, and eyeglasses and wigs, and that sort of thing, and the ones that I talked to were just thoroughly disheartened.

They just had no spirit and just stated they practically had no pride in their profession.

Senator DONNELL. And you predict here in your statement:

> I predict confidently that the enactment of this legislation will decrease the number of physicians produced annually, and that it will very materially lower the quality of the young men who enter medicine.

Is there anything you want to say to amplify that point?

Dr. GOIN. Senator, of course, I have no gift of prophecy, and I have no idea really what will happen if this law is enacted. All we can do is to observe what has happened elsewhere.

It is only reasonable to assume that something like that will have to happen if you enact a law something like this.

The average doctor in Great Britain now has an annual income of about $5,000. Out of that, of course, he has got to maintain his office and pay any assistants that he has; and if he is fortunate enough to have an automobile, he has to maintain that, so perhaps he will wind up with $2,500 or $3,000.

I do not see why a young man would subject himself to the very severe discipline of at least 2 years in college, at least 4 years in medical school, at least 1 year in hospital training, for the purpose of earning the amount of money that he could have earned the first 6 months after he had started his college course.

I mean we are not so highly altruistic that we go into medicine just for the love of humanity, to save people's lives. I think most of us do so, but we want to make our living, and I do not see the point of that kind of an investment for that kind of a return.

Senator DONNELL. Doctor, have you ever seen the book or books of regulations and laws under the British law?

Dr. GOIN. Yes; I have.

Senator DONNELL. Tell us about how large these books are.

Dr. GOIN. Well, the official book of regulations contains 1,310 pages, and it seems to me that I knew it weighed 2½ pounds, but I do not think it is very important.

Then they had a second book which was known familiarly as the doctor's Bible, and that was a digest of these regulations and it was a book, I would guess, of between five and six hundred pages, a fair-sized book. This book the doctor had to refer to constantly to see what he might or might not do.

Senator DONNELL. Yes. That, of course, is not under the history of the system with respect to the last 6 months——

Dr. GOIN. That is under the British compulsory health insurance law.

Senator DONNELL. You do not know whether or not there has been any decrease in the number of regulations under the new law?

Dr. GOIN. I expect they are bigger now.

Senator DONNELL. We had a witness here this morning, Professor Harris of Harvard University, who has been preparing a book entitled

"The Economics of Medical Care." He had not yet seen these regulations of the British Government, but would you regard it as of importance in the preparation of a work of that kind—"Economics of Medical Care"—to become familiar with these regulations?

Dr. Goin. I would certainly think so.

Senator Donnell. Yes.

Have you studied anything about New Zealand, their history down there, with this type of thing?

Dr. Goin. I am mildly familiar with it.

Senator Donnell. I beg pardon?

Dr. Goin. I am moderately familiar with it.

Senator Donnell. Would you just characterize what your understanding is of their experience over there?

Dr. Goin. I understand it has been a great failure, and it is a great national scandal. I know it has taken a great deal more money than they have ever been able to collect from it. It seems to me the figure is 7 percent of the national income has been taken to run that plant.

Senator Pepper. Was that New Zealand?

Dr. Goin. Yes.

Senator Donnell. In order to prepare the "Economics of Medical Care," would you consider that some discussion of New Zealand would be of some importance and enlightenment in determining what would be the medical economics in this country?

Dr. Goin. They should discuss that system, the New Zealand system, the British system, the Russian system, and the French have a new system that needs discussion.

Senator Donnell. Well, Doctor, I do not think there is anything else I want to ask you. Thank you very much.

Senator Pepper. Doctor, again I ask you the question that if this British plan was so degrading to the doctors, and it had so many vices and evils, as you seem to think—as you feel it possesses, would it not seem to you that the opposing political party, that is, the Conservative Party, which is a conservative party, would advocate the repeal or the abolition of this system?

Dr. Goin. Well, Senator, I have some little knowledge of medical care, but I know very little about the expediencies of politics, so I do not know.

Senator Donnell. Senator Pepper, would you be kind enough to let me ask the doctor one question that I forgot a moment ago, and I will not pursue it in any great detail since it is getting late this afternoon.

Senator Pepper. Yes, Senator; go ahead.

Senator Donnell. I intended to ask you whether you had studied S. 1581, the Taft bill, and I wanted to ask you what your impression was about the bill.

Dr. Goin. I have not studied it, but with some small amendments I would be prepared to support it. I do not agree with everything in it, but I have not studied it carefully enough to really be authoritative, but my general impression is favorable.

Senator Donnell. You agree with the general fundamental principles that grants-in-aid——

Dr. Goin. Yes; I do.

Senator Donnell. Rather than compulsory Federal health insurance.

Dr. GOIN. Yes, sir.

Senator DONNELL. And the provision for persons who need the assistance rather than a general provision for everybody?

Dr. GOIN. I do; and I testified before this committee in favor of a like bill at the last session of Congress.

Senator DONNELL. Thank you, sir.

Senator PEPPER. Doctor, I was making the analogy to our experience in this country. For example, we had the old-age and survivors' insurance, which is a pay-roll tax on employees and employers to provide some kind of retirement funds when they retire from gainful employment, reach a certain age; that has been in effect since 1935.

No political party in this country, to my knowledge, has put in its platform any proposal to repeal that law. You do not know of any such proposal?

Dr. GOIN. No; I do not.

Senator PEPPER. You do not know of any leading political figure, such as a candidate for President or generally influential political figures, who have advocated the repeal of that proposal?

Dr. GOIN. No; I do not.

Senator PEPPER. Is it not fair to infer that that is some evidence that there is no persuasive controlling public opinion to get rid of that?

Dr. GOIN. I imagine that is true.

Senator PEPPER. Now, let us take two other cases. We had OPA in effect in this country, and while some of us strongly believed in it there were other people in public life who did not believe in it, and they mustered the votes in Congress to eliminate it. Presumably, because public opinion came to the point where they did not favor it any more, they mustered enough votes to abolish it. Is not that some evidence that if the people generally like anything that it stays in effect, and if they generally do not like it, that political figures advocate its amendment or its abolition, and generally if that is the prevailing opinion that is what happens to it? Is that not some evidence of that?

Dr. GOIN. I think that is correct. I would like to——

Senator PEPPER. Let us take rent control. We had rent control in effect, and there was a difference of opinion about that. Some people conscientiously believed in it, and some people did not believe in it, and there was evidently a lot of opposition to it from the people in the country, and finally there have been successive modifications of it, and finally in a good many instances elimination of it by Federal or by local authority. Does that not rather indicate that, in a country where the people have the freedom of the ballot and speech and press and petition, that they generally—it takes prohibition also—some people conscientiously believed in it, but evidently prevailing opinion finally came to be such that they did not want it, and one of the political parties advocated its repeal, and it was finally repealed.

Now, if those things indicate that in a free country people generally keep what they like of public legislation and get rid of what they do not like, then I ask you again, do you know of any country which has adopted what we call national health insurance, compulsory prepayment for health care, which once having been established it has repealed?

Dr. GOIN. No; I do not.

Senator PEPPER. And that includes countries whose freedoms I do not suppose any of us would question, such as New Zealand and the Scandinavian countries, and in Great Britain, where I do not suppose anybody suggests that they are behind the iron curtain, or that the people do not have the freedom of the ballot in those countries; you do not question the freedom of the people in those countries?

Dr. GOIN. No.

Senator PEPPER. Now, Doctor, the case you put about the——

Dr. GOIN. Senator, before you leave that, though, I would like to make one comment on it, if I may.

Senator PEPPER. Yes, sir.

Dr. GOIN. I do not think that the people always know what they should have. I think they frequently know what they want, and they have to be frequently guided by people with more expert knowledge.

What the people do want I think they should and do get. That is the kind of country we have got. The people vote for the kind of people they want to get things done for them, and they get it done, if the people want this legislation they should have it; that is the American people's right. But it is also my right and the right of other doctors to warn them of that danger; that is all we are doing here. We are trying to persuale the American people, through their elected representatives, that what is proposed here is not a good idea; but, if the people want it, I will grant them the perfect right to do so and keep it on the books forever.

Senator PEPPER. You are entirely fair about that, doctor.

Now, is it not also a fact that, generally speaking, the British Medical Association opposed the health program that is in effect in Great Britain? Did they not advise the people that it was not good for them to have it?

Dr. GOIN. I think that is true.

Senator PEPPER. And the government, and evidently sustained by the people, took the contrary position, and so far it is the law of the land in Great Britain.

Now, doctor, in the case you put about where the lady was treated with indignity by the physicians, do you attribute that—do you think that should be attributed to the fact that they have got this national health insurance program in effect?

Dr. GOIN. I do, indeed.

Senator PEPPER. Or was that just rather the nature of the doctor who did that?

Dr. GOIN. Oh, no; on the contrary, sir, I do indeed attribute it to that because the doctor would not have dreamed of doing it to an actual private patient; but they treated all the patients in the so-called Krankenkasse that way.

Senator PEPPER. Do you suppose anybody, any doctor, has treated with indignity a charity patient in a charity hospital?

Dr. GOIN. Only once, I would think, probably.

Senator PEPPER. You do not think it has ever occurred but once?

Dr. GOIN. To one given patient. The patient went away, or the doctor lost his position, or something. We do not do things that way.

Senator PEPPER. Well, I just wondered whether this was a difference in the way of doing things by the British. Do you mean to say that that sort of thing never happened before this present health insurance plan went into effect in England, but it has happened since; is that your statement?

Dr. GOIN. It was not England, sir; it was in Germany, in 1922.

Senator PEPPER. Oh, this was the German doctors in 1922?

Dr. GOIN. Not England; Germany.

Senator PEPPER. Well, having seen concentration camps and what the Germans did, I do not think that is attributable to the national health insurance.

Dr. GOIN. My point is this: They did not treat their private patients thus. They said, "Come in; good day, Frau So-and-So."

Senator PEPPER. If you think that is an argument against national health insurance, Doctor, you have a perfect right to think so.

Dr. GOIN. Thank you.

Senator PEPPER. Now, I believe you were speaking about a good many of the doctors who wanted to come to this country. Well, that desire to come to this country from other countries is not limited to doctors, is it, Doctor?

Dr. GOIN. I expect that is true, but I have had some correspondence with some who spoke bitterly about the health service and how they would like to escape from it.

Senator PEPPER. A good many business and professional men, I understand, want to come to this country from other countries.

Dr. GOIN. It is my impression that anybody in his right mind would like to come to this country, but these are specific instances of people who wish to come because of the national health services.

Senator PEPPER. Now, you spoke of the fact that they were so busy providing wigs and glasses and eyes, and so on—you did not mean by that that people who went did not go to specialists in those fields? A general practitioner is not supposed to supply a wig, and a man who is not a dentist is not supposed to give dental care, is he?

Dr. GOIN. I suppose that is true.

Senator PEPPER. I gain the impression from your way of stating it that the doctors were so busy giving all these things that they did not have time to treat their patients.

Dr. GOIN. That is the impression I get from them.

Senator PEPPER. That they call on a general practitioner to fit eyeglasses and wigs and false teeth and——

Dr. GOIN. No, Senator; I did not say that; no; just the doctors of Great Britain are so busy; I just include all of them. I did not mean the general practitioner.

Senator PEPPER. I did not think you meant that, but I did not want it to appear in this record that under this foolish scheme they had there they called on the general practitioner to do all these things that were not part of his general field.

Dr. GOIN. No; but they called the doctors of England to do it, whichever ones they happened to be.

Senator PEPPER. The ones that are specialists in that field. Well, now, Doctor, there is nothing wrong about a person who was baldheaded, if he wants to get a wig, getting one; and a person who needs glasses applying for glasses; and a person who needs false teeth from asking for them or getting them, is there? There is nothing wrong about that, is there?

Dr. GOIN. I do not know that I can quite subscribe to that. It seems to me that if I needed a wig I would save up money to buy one.

In spite of the curious economics heard this morning that it was simply impossible to save money, I do not wish to receive a dole from the Government, if you do not mind.

Senator PEPPER. It costs a good deal to have glasses—to buy a pair of glasses—several dollars.

Dr. GOIN. About three bottles of whisky.

Senator PEPPER. Well, are you sure that all the people who need glasses buy whisky instead of glasses, Doctor?

Dr. GOIN. No; but I think a good many do. I still say that you could rearrange the family budget so that you could afford to buy these things.

Senator PEPPER. Well, maybe they could in some cases out of their family budget if they were frugal and fortunate, and would be able to pay for certain aspects of medical care. But just because this plan includes complete coverage, which includes glasses for those who need them and teeth for those who do not have any teeth and even hair for those who do not have hair; it does not necessarily have to be condensed.

Dr. GOIN. No; not on those grounds alone; of course not.

Senator PEPPER. Does it, Doctor? I think that teeth with which to chew make a contribution to the health of the patient, do they not? Do they not do that if they fit well?

Dr. GOIN. I think teeth are of enormous importance.

Senator PEPPER. And glasses, of course, to those who have defective vision, may be very important.

Dr. GOIN. You must not forget, though, that the patient, in going to get this wig and these glasses, still has to go to the general practitioner's office and get a note or something.

Senator PEPPER. I think that is a wise provision, and it is included.

Dr. GOIN. I think it is, too, but it takes up a lot of time.

Senator PEPPER. Well, can you think of any better way, Doctor——

Dr. GOIN. Sure; taking care of the sick.

Senator PEPPER (continuing). To let somebody pass judgment on the matter; that is, the idea that before a patient goes directly to a specialist, is it an unreasonable requirement to say that the general practitioner should recommend the services of a specialist beforehand?

Dr. GOIN. I think, in general, he does in this country, but he does not absolutely have to. It is not under our voluntary care plans either.

Senator DONNELL. Is the Senator asking the witness along this line as to whether the witness thinks that a man who wants to get a wig ought to go first go to a doctor and get his O. K. on it before he gets a wig?

Senator PEPPER. No; I think probably that is the case where the services required would be obvious. [Laughter.]

Dr. GOIN. Perhaps you are right.

Senator PEPPER. I think that the need would be obvious, so that I think it is not necessary to go through a general practitioner. But, in the case of a patient who came in and said that his back hurt him, or a lady came in and had certain symptoms, whether that person should go and take up the time of a cancer specialist and then have the cancer specialist finally say, "Well, I have conducted laboratory tests and everything here for a week, and I cannot find any cancer," and then they go to the heart specialist, and then they go around to the stomach specialist, and so on, and it looks to me as if it is not an unreasonable suggestion that you go first to a general practitioner and let him make a general diagnosis and then refer you to the specialist, especially since that specialist is going to charge extra fees, the kind of a specialist that you need.

We have to balance the interest, Doctor, I suspect, in most things. There is no doubt but what there are going to be a lot of defects in this plan, and there is no doubt but that we will have to keep constantly working at it, keeping it from having too much bureaucracy and too much red tape, but some of us think that that is one of the disadvantages that we may have to put up with in order to solve this very challenging problem of providing means by which the people can pay their doctor and their hospital bills, a matter which is becoming more and more a problem to more and more people in this country and, no doubt, in other countries.

I have one or two other things. I believe Senator Donnell asked you something about making complaints, which is referred to in section 761. Have you made a careful analysis of that section to determine whether the complaint referred to there is a denial of the eligibility of the patient on the ground that he is not within the covered class, for example, as distinguished from the need of the patient for medical care?

Dr. GOIN. I do not think that could quite be the case because it would not get any need provided if the complaint concerned only the question of professional care—that the jury should be composed solely of professional people. Obviously there must be some medical care being given or there would not be any need to provide that.

Senator PEPPER. I am wondering whether the language referred to, where it says—

> The Federal Security Administrator through such units of the Federal Security Agency as he may determine, shall upon his own initiative or upon application of any individual make determinations as to the eligibility of individuals for benefits under this title—

whether you believe——

Dr. GOIN. I do not believe we are talking about the same section of the law. We were speaking about the mechanism through which a dissatisfied person could complain about his service.

It seemed as if it was a rather cumbersome and complicated mechanism which did not seem to wind up any place, but it was not that particular section that you just read.

Senator PEPPER. You would want to preserve the right of the patient who might have been abused and neglected, to have him complain to somebody, would you not?

Dr. GOIN. Of course. Of course, as fine a system of complaints as we can have is the one we have got now. If you do not like me, you just quit. But I take it under this new plan there would be some little trouble for you to go through, and in the meantime you would have to go through a good many bodies of sorts.

Senator PEPPER. Let us take the voluntary insurance plans that are in effect at the present time.

Dr. GOIN. If you do not mind, let us take the one that I know about because I cannot speak with authority about others.

Senator PEPPER. Let us take yours: Yours is the one that is initiated and operated by the physicians in California?

Dr. GOIN. That is true.

Senator Pepper. How long does a member pay for whenever he joins up, for a day or a month or a year or what?

Dr. Goin. Well, a member who has a pay-roll deduction pays for the period of his pay check.

Senator Pepper. You use the pay-roll deduction method also?

Dr. Goin. We do for groups. Those who are no longer in groups can pay quarterly, semiannually or annually, as they prefer.

Senator Pepper. Can any individual in the group be included if he wants to?

Dr. Goin. Certainly.

Senator Pepper. What does a factory do, insure all of its employees—many or all of its employees?

Dr. Goin. Sometimes, and sometimes the employees want to do it themselves.

Senator Pepper. But in every case coverage rests upon the individual application, and the payment of the necessary dues by the individual.

Dr. Goin. That is right.

Senator Pepper. All right. Now, how long does he pay for when he joins up?

Dr. Goin. Well, as I say when he joins in an employed group he just joins for the period that his pay check covers.

Senator Pepper. Say a week or a month or whatever his pay check is?

Dr. Goin. Usually it is 2 weeks or a month.

Senator Pepper. Supposing this individual feels that he wants to go around to see his doctor, and he is not there. He calls for the doctor, and the doctor does not come or he thinks that the doctor did not give him the care that he should have had. What does he do?

Dr. Goin. Just calls another doctor.

Senator Pepper. Pardon?

Dr. Goin. Just calls another doctor, just the same as he would do if he was a private patient of the doctor.

Senator Pepper. You mean that he calls another doctor who is part of the same program.

Dr. Goin. Everybody is part of it.

Senator Pepper. Every doctor in California is a member?

Dr. Goin. For practical purposes. We have 9,788, and I suppose there are 10,500 doctors practicing.

Senator Pepper. I see. All right. But suppose he complains; that he goes to the second doctor, and this doctor treats him and he does not give him the right kind of treatment. Then what does he do?

Dr. Goin. Go to a third doctor. Is that not what you would do if you went to a private physician? There is no difference. If you went to a private physician in your home town and he insulted you, you would walk out. If you went to the second one, and the fellow acted as if he was a little drunk, you would walk out, and that is what this fellow would do.

Senator Pepper. Suppose he goes to one doctor and the doctor starts a treatment and treats him for a little while, and he decides he does not like that treatment, and he goes to the next doctor and says—this doctor asks him—I guess he asks him whether he had been to any other doctor.

Dr. Goin. That is the usual practice.

Senator Pepper. And the second doctor says, "Well, what treatment did you get?" He tells him what treatment he got; and the second doctor says that that is the right treatment, and the patient insists that he wants some other treatment. What does the second doctor do?

Dr. Goin. The second doctor has got to do what he thinks best. No doctor does what the patient tells him to do.

Senator Pepper. All right. Suppose this fellow thinks that he has got a right to the treatment that he should have, the treatment that he is asking for, and he thinks he is not getting the kind of coverage and care that he is entitled to under this system.

Dr. Goin. Of course, I will tell you, Senator, those things do not actually arise in practice. We have occasionaly a psychopathic patient who asks that the treatment be given this way, and we get them finally caught up with occasionally, and then they are removed from society.

Senator Pepper. Doctor, I am asking you, do you not have any system by which complaints may be made in your plan?

Dr. Goin. Just write a letter and complain.

Senator Pepper. Is there anybody who can hear that complaint?

Dr. Goin. Certainly, I can, for example; the board of trustees can; the medical director can.

Senator Pepper. Then, does somebody have authority to give redress?

Dr. Goin. They certainly do. Right now, too.

Senator Pepper. And if the patient went and insisted that he was entitled to a certain kind of care, and you did not think he should have it and denied it to him, would he not have a right to appeal and complain about it?

Dr. Goin. I think if a patient went to a doctor and insisted that he should be treated—let us make it simple—with penicillin, and the doctor thought he should have sulfdiazine, I do not think anybody would pay any attention to his complaint. That is not a complaint; that is just the patient trying to superimpose his judgment on the doctor's, and the doctor will not do it, any more than if you are practicing law you would mind what I would want done in a legal case where I retained you for counsel.

Senator Pepper. All I am asking is, is it not a fact that under your system or any system, either voluntary or compulsory, you have got, in fairness, to give the patient a right, and to establish a procedure by which he may complain, and you provide somebody to hear his complaints?

Dr. Goin. I do not think so; I do not think so, Senator.

Senator Pepper. Well, do you not say that is what you do?

Dr. Goin. We have no change in the practice of medicine under our system, and the patient has the same rights, and the same privileges, and the same recourses that he had if he just goes to me as an ordinary doctor to pay his fee.

Senator Pepper. Yes, doctor.

Dr. Goin. He will complain to me. He will complain about me. He will complain to his friends. What else will he do? He just comes as a private citizen——

Senator PEPPER. But he has already paid you in this prepayment case, and it is not like going to a private doctor.

Dr. GOIN. He has sometimes paid me my fee even before he has gotten mad at me.

Senator PEPPER. But it, in private practice, ordinarily does not create a situation where the patient pays before you finish with him.

Dr. GOIN. No, but sometimes you insist that the patient pay something.

Senator PEPPER. And in that case if he does not like the care you give him he goes to another doctor and just does not pay you when you send him a bill.

Dr. GOIN. That is right.

Senator PEPPER. But in the prepaid cases his fee is already paid.

Dr. GOIN. He will just get the care; it is just a heavier burden on the plan, that's all.

Senator PEPPER. Do you or do you not give your patients, those who are covered, an opportunity to complain to some board or agency or some official, and give that board or agency or official the power to hear the complaint, and if it is a justifiable case, give redress?

Dr. GOIN. We have no system set up for hearing complaints. We only treat them in the ordinary courteous manner. We listen to anyone who has a complaint.

Senator PEPPER. When you say "we," who is "we"?

Dr. GOIN. Our system.

Senator PEPPER. Your what?

Dr. GOIN. The California Physicians' Service. The mail which comes in depends on where you address it. I get mail addressed to me personally.

Senator PEPPER. You are the head of it?

Dr. GOIN. I am the president.

Senator PEPPER. You are the president?

Dr. GOIN. But mainly letters go to the office of the California Physicians' Service, and there they are opened by mail girls, and assorted by where they think they should go, and a letter complaining of medical care will arrive at the desk of the medical director, who will make some courteous response. There is no complaint that needs to go through the steps up to an adjudication; we do not have it.

Senator PEPPER. But you do have machinery by which complaints may be made and consideration may be given to the complaint?

Dr. GOIN. No; we really do not. I say some person will eventually get a letter and make a reply to it, but there are actually no steps through which you go to make a complaint or to complain. If you were dissatisfied you would simply write a letter to California Physicians' Service, and state what your complaint was, and presently you would get a letter from someone saying that they received your letter, and they would try to investigate it and straighten it out for you, and try to do so and so.

Senator PEPPER. The individual may not be able to get his money back, and you may treat his complaints in just a perfunctory way, as you indicate you do. I suppose the only redress he has got, as you suggest, is to pull out of the system.

Now if, however, there is to be compulsory payment required, then obviously there would have to be some machinery provided by which complaints could be made and heard, would there not?

Dr. GOIN. Oh, yes. I was not making any complaints about the existence of such a system.

Senator PEPPER. That is all, Doctor. Thank you very much for your views.

Dr. GOIN. Thank you, sir.

Senator PEPPER. The hearings will be recessed until 10 o'clock next Tuesday morning when they will be resumed.

(Whereupon, at 5:05 p. m., the subcommittee adjourned, to reconvene at 10 a. m., Tuesday, May 31, 1949.)

(Subsequently Senator Murray submitted the following personal statement and accompanying article for inclusion in the record:)

Senator MURRAY. Since the San Francisco municipal health service plan represents the only American experience with compulsory health insurance, I think the record should contain the following article setting forth the origin and development of that plan and giving a picture of what it has meant to the municipal employees and the families of those employees in the city of San Francisco. It is also worth noting that the firm of Whitaker & Baxter, currently spearheading the American Medical Association's attack on national health insurance, had a hand in the attempt of organized medicine's effort in California to wreck this significant local experiment.

[From the San Francisco Chronicle (This World), February 22, 1948]

THE PATIENT'S DILEMMA—San Francisco's Health Service system worked well for 8 years until the city's doctors suddenly saw the specter of socialized medicine. Chronicle staff writer Ruth Newhall herewith reports on this controversy, which threatens the system.

Russell Cardin, who works in the engineering department of the city and county of San Francisco, woke up before dawn early one day last November with pains in his abdomen. The pains were general, and rather nauseating. He thought back over his previous day's diet—but this was no ordinary attack of indigestion. He woke his wife.

Mrs. Cardin (for the purposes of this article) took his temperature and found he had none. Cardin went back to a restless sleep. At 6:30 a. m. he got up and started to dress, and the pain became more intense. His wife sent him back to bed and telephoned a doctor whom we will call Carey Drumm, the physician who had attended the family when they all had flu a few months before.

Dr. Drumm arrived, and Mrs. Cardin reminded him that they belonged to the municipal employees' health service system, and gave him their system number. He took a case history, asking questions about Mr. Cardin's diet the day before, whether he had frequent indigestion, whether the pain was constant or recurring. Fairly constant now, Cardin said, and a little more concentrated on the right side. The doctor found his temperature was 101° by this time.

At that point, of course, most amateur diagnosticians would have shouted: "Appendicitis!" They would have been right. Dr. Drumm went at it a little more cautiously, probing Cardin's midriff first on the left until he worked over to the sensitive spot that drew up Cardin's right leg and made him grimace in a spasm of pain.

The doctor called Stanford Hospital, arranged for a bed in the surgical ward, asked them to be ready for immediate blood counts and to prepare surgery. He then called HEmlock 1-7100, and asked to speak to Dr. Keenan, medical director of the health service system. He informed Dr. Keenan that Russell Cardin was being hospitalized for an emergency appendectomy. (Actually, since the operation was an emergency, Dr. Keenan's approval was not necessary.)

Mrs. Cardin sent for an ambulance, gave their health service system number, and asked the ambulance people to bill the system directly.

The rest of it was regular procedure—the ear-pricking for blood count, the trip in the gurney to the fourth-floor surgery, the dull awakening, the camaraderie of ward convalescense. The best part of it all was that Russel Cardin's biggest worry was when his scar would heal. The fact that the total charges for operation, hospital, and associated services added up to more than his $350 monthly salary did not bother him a bit.

Cardin's only outlay on his faulty appendix was $3.50 for some medicine prescribed by his doctor. The rest of it was taken care of by the health service system. Out of each monthly pay check Cardin had had $12 deducted—$3.40 each for himself and his wife; $2.60 for each of his small daughters. He was now collecting the benefits.

But on November 12, the fourth day of convalescense, his wife brought him a letter which had been written to them by Dr. Drumm. It said, in part:

"In accord with the action of more than 900 of my colleagues in the medical profession, I have submitted my resignation as a member of the medical staff of the health service system, effective November 10, 1947.

"This decision is not arbitrary on my part and I am deeply regretful that it is necessary, but I cannot in good conscience remain on the staff of a system which denies you adequate medical and hospital care in time of illness. * * *"

To Russell Cardin, who had just received more than adequate medical care at the system's hands, the whole thing was a little puzzling. To the other 19,000 members and dependents in the system, it was confusing though not unexpected. A battle had long been raging in the press and pamphlets between the municipal employees' health service system and the San Francisco County Medical Society. This was the culmination.

The implication of the dispute went beyond the matter of municipal employees; it was a problem which concerned every citizen. The Health Service System, as the only compulsory municipal prepaid medical plan in the Nation, is a pattern, in a small way, of various plans that have been drawn up for state-wide and nation-wide public health insurance.

Like many other medical service systems, the San Francisco Health Service System grew out of the depression, when a large proportion of the public realized that it could not afford to get sick, and that there was something to be done about it.

Medical insurance plans were born all over the Nation, and were fought to the last ditch by the American Medical Association, which preached the "sacred personal relationship between doctor and patient" but which overlooked the fact that many doctors were going broke and patients were dying of neglected ailments, because they had no money to pay.

The growth of prepaid medical care in the 1930's swung the medical associations around to the point where they found their best defense was offense. They took to supporting group plans which met with their approval, or even to sponsoring their own. Such a sponsored plan is the California Physicians' Service. By going along with voluntary insurance plans, the medical associations have hoped to protect their members from compulsory or State-controlled medical plans. Some 50,000.000 people in the United States today are now enrolled in medical insurance plans, of one sort or another.

The organizers of the San Francisco municipal health insurance plan decided to make the plan compulsory, on two grounds: First, it would help insure the city against loss of efficiency through neglected health; second, it would keep the expense per employee lower, since the chronically well would help foot the bill for the chronically ill.

After city employees had voted 8 to 1 in favor of some sort of compulsory health insurance for themselves, the matter was submitted to San Francisco voters as a charter amendment. In March, 1937, the people voted it into the charter.

The amendment provided that all employees of the city, county, and Board of Education would have money automatically deducted from their pay checks to support a health system. Conscientious objectors, like Christian Scientists, were exempted, and the board was given the additional power to exempt people already "adequately" covered by other health plans, or employees earning over $4,500 yearly.

The charter amendment went into considerable detail. It provided that the employees' health system would be run by a board of nine, to be elected by members of the system. The specific plan for providing medical care would be up to the board.

The board itself, composed of clerks, teachers, firemen and other such nonexperts, labored long and mightily to discover how to operate a health insurance plan.

They talked to doctors, insurance men, statisticians, hospitals, and came up with a bewildering variety of choices. They finally settled on a scheme developed by Dr. Walter Coffey under which the health service system would run it own show: Collect its own premiums, maintain its own office staff and medical adviser, and pay out the money directly to doctors, hospitals, ambulance services, and laboratories.

The longest discussion came over medical fees. At length, a unit system was established, in collaboration with the county medical society. Under that system a certain number of units is asigned to each medical service (examples: 5 units to a first office visit, 2½ for subsequent ones, 125 for an appendectomy).

As the plan developed, there were squabbles with the society, and the unit system was readjusted. Certain services had to be eliminated to cut down costs.

Hospital service was limited to 21 days a year for employees, 10 days a year for dependents, and there were financial limitations on X-ray and laboratory work for people not confined to hospitals.

The amount to be paid by each employee was established first at $2.50 per month, as a sort of shot in the dark; it has since been upped, in two successive raises, to $3.40.

The first pay-check deductions were made in March 1938 just a year after the system had been authorized by the voters. Then there was a 6-month delay while legal hatchetmen went to work on the system, to test its constitutionality. It passed the State supreme court unscarred.

Within the first week of the plan's operation, 800 physicians signed up on the panel, and within the first year the panel included 1,056 of San Francisco's 1,250 doctors.

The doctors were slated to get the biggest single slice of the take. However, they were also to be paid last. The much smaller costs of administration, hospitals, laboratories, etc., were first paid in full, and then the residue (normally something over 50 percent of the total fund) was to be distributed among the doctors.

They were supposed to be paid at the rate of $1 per unit, but only if there were enough money in the left-over kitty to go around. If the bank balance was not enough, in any one month, to pay 100 cents on the dollar, then the unit was cheaper. During the first 4 years the unit was pretty badly depreciated. Once it went as low as 50 cents; the average was a little over 80 cents per unit ($100 instead of $125 for an appendectomy).

However, the health service system was not alone in its depreciated unit. The California Physicians' Service, started up as a doctor-sponsored medical insurance plan after doctors became convinced they could no longer swim against the rising tide of prepaid medical care, likewise had to depreciate its unit.

The medical society grumbled from time to time, claiming that because of the cheapness of the unit the doctors had lost some $300,000, that sum representing the difference between the money paid and the standard $1 per unit.

The health service system answered with its own figures: Available statistics indicated that doctors were collecting, even under reduced schedules, twice as much money from city employees as they ever had before.

The early years were rough ones all around. Politics raised its ugly head on the board of the health service system. One board member died and the rest were deadlocked, 4 to 4, on every decision. In the middle of this ruckus Dr. Walter B. Coffey, originator and medical director of the system, retired.

Dr. Anthony Diepenbrock was appointed temporarily as assistant medical director, with the understanding that when the board was complete he would be made director. But the weight of politics on the board swung the other way. Dr. A. S. Keenan was appointed to the $600-a-month post as medical director, and Dr. Diepenbrock resigned in a huff.

Some health service partisans place some stress on the fact that the slighted Dr. Diepenbrock is currently president of the county medical society, and as such, fostered the resignation of the 922 doctors from the panel.

There is more to the resignations, however, than any matter of simple personal animus, or even financial dissatisfaction. In the matter of finances, the health service system record from 1942 on shows a healthy picture. Doctors got a straight dollar per unit from mid-1942 until early last year. Despite that a little over a year ago the county medical society grew restive.

The society's committee on health and hospitalization insurance reported in the society's bulletin last January that an informal poll of doctors had showed that 95 percent of them were dissatisfied with the health service system fee schedule, and wanted a raise. The report went on to call the system a financial failure, and recommended that the medical profession quit its association with the service.

In the same report came the tipoff as to the real reason for the doctor's dilemma:

"We are used in Sacramento as an example of a community where doctors not only sponsor but enjoy the fruits of compulsory health insurance.

"The medical profession has publicly professed to be unalterably opposed to compulsory health insurance, and as long as we continue to participate in this system we are inconsistent, we are living a lie."

But the medical society preferred not to stress this point. There were other issues more suitable for public presentation. In February, March, and April, immediately following the bulletin's blast, the unit value fell off for the first time in nearly 4 years, to 92, 80 and 91 cents respectively.

Dr. Keenan, as medical director of the health service system, looked over the health service report and came to a conclusion, which may or may not have been correct: That doctors, dissatisfied with their take from the system, had been "raiding" the treasury by a complicated rigamarole of uncalled-for-medical attentions.

Once before in the system's history—in 1939—the then medical director had called down the doctors for cheating to gain extra units. At that time Dr. Coffey had cited one case where a doctor had billed the system for 40 home visits to two children in the same family with uncomplicated measles; another where chickenpox had required seven home calls; and other spectacular superservice at Health Service System expense.

One weakness of a medical plan like the health service system is that a doctor can readily pick up a little extra cash by performing unneeded services. Some health service system members have long joked about the large number of office visits or X-rays required by minor ailments, though, that, of course, is not true of all.

About one-third of the doctors on the panel never served even a single health service system patient, so for them the whole discussion was in the realm of theory. Though over 11,000 people used the service during the past year only 15 doctors had over 100 patients each from the health service system and only two took in over $4000 each from the service.

Last May Dr. Keenan wrote a less specific bill of particulars which succeeded only in giving the county medical society just the ammunition it needed for a public fight.

In a letter to the 1000-odd members of the doctors' panel, he asked that doctors refrain from having patients return to the office for unnecessary treatment of minor ailments, that they limit laboratory and X-ray examinations to those necessary for diagnosis, and that they not hospitalize patients, except in emergencies without permission of Dr. Keenan himself. He added a paragraph that was to boomerang:

"Much of the so-called medical knowledge gained (from magazines, public lectures, and over the radio) has given people a mass of false information. It has brought about many unnecessary visits to the doctor to get treatment for trivial things. Such minor ailments could be treated as well by their home remedies as by the doctors. Such needless calls take up the doctors' time and add a great expense for the system."

The medical society, through astute Public Relations Counsel Clem Whitaker, pounced on this material and paraded it through the city hall and the streets. In three-column advertisements in the daily papers the society announced: "City employees, your doctors have been told to deny you adequate medical care." The ad advised members of the system to abandon their plan as medically and actuarily unsound, and to demand that the board either contact with another existing system or turn to the indemnity system under which cash benefits for illness are paid the patient.

Next the society set about collecting resignations from its members. Form cards were sent out, which doctors had only to sign to make their resignations effective whenever the medical society decided the time was ripe. The ripening came on November 10. Some 920 doctors resigned and the health service system was left with only 90 doctors on its panel.

Since that time there have been rapprochements and withdrawals. At first the doctors refused to negotiate unless the "compulsory" feature of health service system were withdrawn (an impossibility according to charter provisions). Then, at the behest of Supervisor George Christopher, who has manfully tried to mediate the whole dispute, they agreed to put the whole issue up to 60-day arbitration. During that 60 days, they said, their members would continue to treat health service system members as private patients. The health service system balked and said it would arbitrate only if, during the 60 days, the doctors returned to the panel.

Today the deadlock continues. The health service system is casting around for other plans under which to provide service to its members. The Permanente Foundation has volunteered to take in the city employees, buts its closed panel of doctors violates the charter provision that employees must have a free choice. There is a possibility that employees may be allowed to vote on the Permanente plan, with those voting for it being allowed to join.

Since the resignation of the doctors, most employees like Russell Cardin have been continuing with their own doctors, resigned or not. The doctor then bills Cardin, who pays him, and submits the receipted bill to the health service system, which repays him according to the unit schedule.

There is one hitch in this, from the employee's standpoint. A few doctors, particularly when serving low-income patients, will adjust their bill to the standard health service fee. But most are charging their patients what they think the traffic will bear. Some doctors are charging $150 to $200 for an appendectomy, knowing that the patient will get $125 back from the system, and figuring that he can dig up the extra money out of his own pocket.

This system of upgrading payments is, of course, in standard medical tradition. The California Medical Association's own plan, the California Physicians' Service, provides that patients whose family income exceeds $3,000 a year can be charged extra fees, at the doctor's discretion. In this way, of course, a doctor does handsomely. He is guaranteed payment for the low-wage group which might otherwise never pay a cent, and still can collect standard fees from the other income groups.

Strangely, since the resignations, all but a few of the laboratories and hospitals have likewise billed the patient directly, refusing to have any truck with the health service system. Right now city employees who do not confine themselves to the 90-man panel have to have enough money on hand—or have to borrow enough—to pay their bills, and then wait for indemnity from the health service system at a later date. It is not a happy situation for the 19,000 members of the system, who need many more than 90 doctors to care for their ailments.

Cardin and most of his fellow workers thought they had a very nice thing in their health service system. It was not perfect—they still got nicked for things like their wives' pregnancies and their children's tonsillectomies—but the burden of unanticipated catastrophe was off. Most of them are frankly puzzled as to what went wrong.

Aside from the argument that the health service system wants them treated as "second-class patients," the argument that most of them have heard most often from their doctors is that there is "third-party interference" between doctors and patient. By that, the doctors mean that they were required in all except emergency cases to call Dr. Keenan and get his approval before hospitalizing a patient.

Dr. Keenan himself claims that he has never refused hospitalization, and that the call was necessary mostly so a check could be made to see if the patient had yet exhausted his allotted 21 hospital days per year.

But the health service was guilty of bungling. No doctor likes to be told that he must phone for approval of his treatment. Since the resignations, the health service system has paid bills according to its usual schedules without the formality of prior approval. So that, it appears, was an issue which the health service system injected unnecessarily.

Actually, the municipal employees of San Francisco are part of a fight that is being waged here and abroad. On one side of that fight are the doctors, each of whom has a tremendous personal and financial stake in his profession, which involves long and expensive training. On the other side is the social and economic problem of health for the masses of people.

The words "socialized medicine" crop up frequently in connection with the doctors' arguments regarding health service system. "Socialized medicine" is a phrase that will set the instruments clattering in any doctor's office, and the mercury jumping in his sphygmomanometer.

Behind letters, or fees, or any other of the minor issues in the case of the health service system is the realization, on the part of the county medical society, that they have been nursing a serpent in their bosom. During the arguments on Governor Warren's plan for State-wide medical care, they found that they were used by the proponents of "socialized medicine" as an example that such a system can work. The result: It has stopped working.

The same argument, with the issues more sharply defined, is going on today in Great Britain. There the Labor Government has decreed the socialization of all medicine as of next July, at which time every doctor in Britain will be put on a $1,200 annual salary, plus $3 per patient treated.

At the moment, anything so extreme would be unthinkable in this country. But that is what gloomy doctors see in the future if mass compulsory insurance like health service system is allowed to survive.

The fireman, the policeman, the park worker, the tax collector and the other five city employees who form the high policy board of the health service system are meanwhile left with a pressing problem: Can Russell Cardin ever again call his own doctor and go under the anaesthetic with so few worries?

[From the San Francisco News, June 1949]

WHAT PRICE HEALTH?—CALIFORNIA TOPS NATION IN MEDICAL CARE COSTS—STATE SURGICAL CHARGES 139 PERCENT OF THOSE AT NATIONAL LEVEL

(By George Dusheck)

Mrs. M., a young housewife and the mother of two children, visited her family doctor to ask about a growing lump in her neck. He removed it and sent the tissue to a pathologist for examination.

Microscopic examination revealed the cells were malignant cancer cells, probably migrants from the nearby thyroid gland. Mrs. M. entered a hospital here and a specialist in this type of surgery, to whom she had been referred by her family doctor, removed the gland. Her recovery was uneventful, as the medical case histories put it.

Her husband, who earns approximately $5,000 a year, paid the following bills:

X-ray examination of neck and chest	$12.50
Biopsy (removal of tissue for examination)	100.00
Use of operating room for biopsy	20.00
Pathologist's fee	10.00
Removal of the thyroid gland	500.00
Anesthetist for thyroidectomy	45.00
Nine days' hospitalization, drugs, and operating-room fee	227.83
Total	915.33

More than 70 percent of this sum—$679.50—went to the family physician, the radiologist, the pathologist, the operating surgeon, and the anesthetist. All are licensed doctors of medicine.

This is larger than the doctor's usual portion of general medical expenses, which has variously been estimated at from 25 to 44 percent, but it points up a medical fact of life:

Medical care in California is the most expensive in the Union according to most available statistics. (The State ranks sixth in per capita income.)

A year ago the Actuarial Society of America, whose members figure the complicated tables for insurance companies, published the results of a survey of doctors' charges. The survey was based upon more than 50,000 claims filed with insurance companies.

The level of general surgical charges in California, the report showed, is 139 percent of the national level. Lowest was South Carolina—72 percent of the national level.

The difference is even more striking in the specific case of childbirth. Average of charges by California doctors is 161 percent of the national average. The low is New Mexico—66 percent.

From time to time the magazine Medical Economics (a Philadelphia publication with an editorial policy tailored to the official American Medical Association viewpoints) surveys the income levels of the Nation's doctors.

Here are the results of three surveys made during the past 10 years:

	National average	California average
1939	$7, 365	$8, 798
1943	13, 605	19, 010
1948	17, 476	24, 385

The Medical Economics surveys have been attacked by some doctors on the grounds that (1) only about a third of the doctors polled responded and (2) those not responding are probably in the lower income brackets. (The argument is that the poorer doctors don't like to reveal their inferior status.)

These objections, however, apply equally to all regions and States surveyed. No one denies that California doctor's incomes have always been higher than the national average; are today nearly 40 percent higher than the national average; are the highest in the United States.

Of course, as physicians are quick to point out, the same surveys show that office expenses of doctors in the West are higher than the national average. In California this expense figure is 41.7 percent of the average gross income, or approximately $10,000 a year.

The average net income of a California physician is, therefore, about $14,000 a year.

The $10,000 in office expenses is broken down, roughly, like this: Salaries (to nurse, receptionist, technician), 35 percent; drugs and supplies, 17 percent; office rent, 15 percent; automobile expense, 8 percent; instruments and equipment, 8 percent; miscellaneous, 17 percent.

The doctor's principal income comes from the fees of his patients. Some earn other income from teaching or from participation in private group health plans—such as the Southern Pacific Co.'s system.

It is not possible to generalize about the fees charged for specific services by doctors. There is a long-standing belief in the United States, for one thing, that fees are adjusted to the income level of the patient.

This is done often enough to perpetuate the belief, but if the system were universal and accurate, every income group would pay out approximately the same percentage of its annual income for medical care.

Instead, a survey by the California Medical Association some years ago showed the lowest income groups pay out about 5 percent of their incomes for medical care; while the upper level income groups spend as little as 1 percent. This is in spite of the fact that the poor receive much free medical service.

The fee schedule of the California Physician Service—the doctors' own prepaid voluntary health insurance plan—was drawn up and agreed to by the doctors themselves. It applies to California families with a net annual income of less than $3,000. This figure is considerably lower than the average family income in California, according to preliminary studies by the State chamber of commerce. However, C. P. S. trustees are expected this week to raise the breaking point to $3,600, on recommendation of the C. M. A.

This C. P. S. schedule lists $5 as the charge for both office and home visits; $3.75 for a hospital visit.

(A group of San Francisco physicians surveyed by the University of California's Heller committee for research in social economics reported they charged $5 for an office visit; from $5 to $8.25 for a home visit; from $4.50 to $6.25 for a hospital visit. These charges were for families with incomes of $12,000 a year and more.)

The C. P. S. charge for delivering a baby, including prenatal and postnatal care, is $100. A Caesarean section costs $150. (The Heller committee did not include this item in its survey. One writer on the News paid $300 for a Caesarean delivery.

The C. P. S charge for removing tonsils (in children under 15) is $40. (The doctors queried by the Heller committee for the executive budget group mostly charged $75 for this; one charged $100.)

The C. P. S. schedules list removal of an appendix at $125. (The Heller group of doctors charged upper-bracket families from $200 to $350 for this operation, with most charges $250.)

The C. P. S. fee for removal of the gallbladder is $200. (The group of doctors surveyed by the Heller committee charged their patients from $325 to $500 for this.)

C. P. S. charges for various kinds of gastric ulcer operations range from $50 to $200. Other C. P. S. charges: Removal of the thyroid gland, $175. (Mrs. M. you will recall, was charged $500.) Psychiatric examination, $15. (Actual charges in this field range from nothing, in some free clinics, to $25 an hour for wealthy neurotics.) Chest X-ray, $10. (The Heller group of doctors charged $10 to $15.) More complicated X-ray series—such as gastro-intestinal with opaque barium enema—cost up to $40.

The C. P. S. plan does not provide for eye examination or glasses, but the Heller committee surveyed a group of dispensing optometrists who charged $8.50 to $10 for lens and the same amount for frames.

The Industrial Accident Commission of California pays $15 for a complete examination of eyesight under present fee schedules. The California Medical Association has asked that this be increased to $22.50, to bring it more in line with average charges in the State. (One member of the News staff paid $20 for an examination recently; another paid $25.)

It is apparent that many doctors feel the C. P. S. fees are too low, and charge nonmembers whatever they please. At a recent meeting of the California Medical Association in southern California one physician complained that C. P. S. was "no better than socialized medicine" and said it has cost California physicians $10,000,000 in the decade since it was started.

It should probably, therefore, be interpreted as a minimum fee schedule rather than one physicians agree is fair for middle-income families.

[From the San Francisco News, June 17, 1949]

WHAT DOES IT COST TO BE SICK?—COST OF MEDICAL CARE UNPREDICTABLE FACTOR

(By George Dusheck)

How much does it cost to be sick? How can an American family, regardless of means, budget for sickness? Is it a private problem—or a public problem?

Mr. D., a 53-year-old accountant, earned $500 a month, working for a contractor on Guam. Living costs were high, however, and he and his wife had saved little when, last year, it was discovered he had cancer of the throat.

They returned to San Francisco and sought medical care for Mr. D. Here's how the bills added up at the end of 9 month's illness:

X-ray diagnosis and therapy	$310.00
Doctor's and consultant's fees	1,070.00
Hospitalization	527.40
Drugs and dressings	509.97
Taxi, fares to and from radiologist	141.20
Total	2,558.57

This doesn't include the special foods that Mr. D. had to eat—nor the rent, utilities, and other family living expenses which continue whether a man is sick or well.

At the end of last month Mr. D. died—and on Memorial Day his widow added to her inheritance of medical bills the expenses of his funeral.

ANOTHER CASE

Mr. O. is a newspaperman, aged 37, who earns a monthly wage similar to Mr. D's. Last fall he felt tired and sluggish for a week or 10 days on end. "You probably need some vitamins," his wife told him, so he stopped in a drug store near the office and bought a bottle. It cost $2.37, including tax.

He took them for a few days and then forgot. His tiredness disappeared, possibly because of the vitamins or possibly because he got a full night's sleep several days in a row.

As far as Mr. O. can remember, $2.37 was the total of his medical expenses during the past 12 months.

EXTREMES IN RANGE

The respective illnesses of Mr. D. and Mr. O.—if Mr. O. could be said to have been sick, are extremes of the medical care cost range. But perhaps Mr. O. next year may be in a situation similar to Mr. D's. How can he prepare for it? Must his family face the same expensive and tragic prospect as did the widow of Mr. D.?

The answer to this question is in the problem No. 1 category today before the American people and the medical profession. The answer is being sought by Government, by doctors—and in every household.

Those who support the traditional method of paying for medical care (as exemplified by the experiences of D. and O.) like to point out that Americans spend less for medical and dental service than for tobacco, cosmetics, liquor or movies.

COST ESTIMATED

This is undoubtedly true, although the best figures are only intelligent guesses.

In 1948, for example, the total income in California amounted to 16.7 billion dollars, according to the State chamber of commerce. If the average expenditure for all medical care with 4 percent of each family's income (as indicated by several surveys during the past 20 years) then California's out-of-pocket medical care bill was $668,000,000.

If each of the State's 10,264,000 men, women and children (population estimate by the California Taxpayers Association at the beginning of 1949) paid his share of this bill, it would cost each person a little over $65.

UNCERTAIN LIABILITY

A man who smokes a pack of cigarettes a day, at 18 cents a pack, spends $67.70 a year. The per capita expenditure for alcoholic beverages in California is more than $119 each year, according to a 1947 survey by the Wholesale Liquor Distributors Association of northern California.

Measured against figures like these, the per capita expenditure for medical care looks reasonable enough.

The population does not consist of Mr. Per Capitas, however. It consists of Mr. D's and Mr. O's.

The cost of medical care is not only expensive—it is unpredictable and usually unbudgetable, chiefly because it is an indefinite and intangible liability to the average family. Who knows when illness will strike, how long it will last, what treatment and care will be needed?

It is true that almost any person can budget $65. Even a man with a wife and two children, if he is steadily employed at a living wage, could pay $260 out of his annual income for medical care, including dentistry and hospitalization.

If California's annual 668 million dollar bill were really spread equally over the population and everyone was compelled to pay his share—

PROGRAM CREATED

The State would have compulsory, Statewide health insurance!

Gov. Earl Warren has three times proposed this plan—on a much less-than-comprehensive scale—to the State legislature. It has been defeated each time. California Medical Association calls it "socialized medicine."

A similiar struggle is under way in the Congress. The United States equivalent of the Warren health insurance bill (although more comprehensive) is that extension of the social-security program which has been urged by President Truman and Oscar Ewing, Federal Security Administrator, and has been introduced into the Senate as S. 1679. There are many other suggestions.

Those who lead the opposition to the Truman and Warren health insurance proposals—chiefly the members of the medical societies—are themselves revolutionists, however. Almost all doctors freely admit that Mr. D. and the thousands of other persons similarly overwhelmed with catastrophic illness each year cannot bear this burden all by themselves.

California medicine has led the way for the rest of American medicine in seeking some way of joining the medical cost revolution without losing all of the power which doctors have traditionally exercised in both the scientific and economic aspects of medical practice. The doctors have come—reluctantly in many cases—to accept the principle of voluntary prepaid health insurance, while fighting hard against any compulsory health insurance plan, whether Nationwide or State-wide.

Ten years ago the California Medical Association advanced $37,000 from its treasury to the California Physicians Service, newly organized under the leadership of Dr. Ray Lyman Wilbur, which proposed to provide medical and hospital care for groups of workers and their dependents on a prepaid, nonprofit basis.

The step was taken only after prolonged debate in the CMA and in face of frank suspicion by the American Medical Association that the plan was a preliminary step toward "socialized medicine." It seems probable that only the prestige of Dr. Wilbur, then president of Stanford University, gave CPS its chance.

Today CPS has 600,000 members and does an annual gross business of $15,000,000. In the same decade the Blue Cross plan for prepaid hospital care, started in the East, has grown in California to include 1,100,000 persons. Blue Cross paid out $9,207,012 last year in hospitalization benefits.

Group practice plans—such as the Permanent Health plan of Oakland and the Ross-Loos group in Los Angeles—have also grown in size and scope since 1939.

In addition, there are 144 private insurance companies writing health and accident policies in California. It is difficult to find out how many persons are covered by medical and hospital-care policies by these companies. In 1948 they paid out $1,278,139 in benefits on such policies, according to the State insurance commissioner's annual report.

The growth of these plans reflects the seriousness with which Mr. D's friends and neighbors regard the problem of modern medical care, and many, along with healthy (and lucky) persons like Mr. O., are buying some form of protection against the financial risks of illness, each thinking to himself: "Next year may be my turn."

Those who have not taken some such precaution are regarded as incurable optimists; or prefer to "take a chance." Many, of course, are ineligible.

Along with the issue of how medical care is to be paid for by families of low and moderate income, there is another controversy:

Is the amount of medical care available to the people enough to meet all their needs? Are there enough doctors, nurses, technicians, health officers and other personnel? Are there enough hospitals?

The News will examine the facts which lie behind these public questions, in a series of articles of which this is the first.

(Subsequently Senator Murray submitted the following personal statement and accompanying letter for inclusion in the record:)

Senator Murray. In practically all of the American Medical Associations' literature, it is alleged that Lenin said, "Socialized medicine is the keystone to the arch of the socialist state." Although no American places much credence in the statements of Lenin, I think it is of interest to know that the AMA apparently invented this quotation. Many scholars throughout the country have been unable to find it. As an example, here is a letter that I received from the Library of Congress, the greatest research organization in the world:

The Library of Congress,
Legislative Reference Service,
Washington, D. C., May 2, 1949.

Hon. James E. Murray,
United States Senate, Washington, D. C.

Dear Senator: The purported quotation from Lenin to the effect that "Socialized medicine is the keystone to the arch of the socialist state" has been the subject of considerable search from time to time. However, all of our efforts to trace this or similar statements by Lenin have been to no avail.

Our Russian specialist, Dr. Yakobson, states that in the premises the Senator's doubt as to the authenticity of this quotation is justified.

Very truly yours,

W. C. Gilbert,
Assistant Director, Legislative Reference Service.

NATIONAL HEALTH PROGRAM OF 1949

TUESDAY, MAY 31, 1949

United States Senate,
Subcommittee on Health of the
Committee on Labor and Public Welfare,
Washington, D. C.

The subcommittee met, pursuant to adjournment, at 10:45 a. m., in the committee hearing room, Senator James E. Murray (chairman) presiding.

Present: Senators Murray, Pepper, Neely, Taft, and Donnell.

Senator Murray. Gentlemen, the hearing will come to order.

The first witness this morning will be Mr. Nelson H. Cruikshank, director of social insurance activities, American Federation of Labor.

Mr. Cruikshank, will you take the stand, please. You may proceed.

STATEMENT OF NELSON H. CRUIKSHANK, DIRECTOR OF SOCIAL INSURANCE ACTIVITIES, AMERICAN FEDERATION OF LABOR

Mr. Cruikshank. Mr. Chairman, I have a prepared statement here which I believe was furnished your committee. With your permission I will read it and if there are questions, then I will be glad to answer them.

Senator Murray. You may proceed.

Mr. Cruikshank. My name is Nelson H. Cruikshank, and I am director of social insurance activities for the American Federation of Labor. My office is in the American Federation of Labor Building, 901 Massachusetts Avenue NW., Washington, D. C.

I wish to express to this committee my appreciation for the opportunity to appear as a representative of the American Federation of Labor. My purpose in appearing here this morning is to present on behalf of the nearly 8,000,000 members of the unions affiliated with the American Federation of Labor our support for Senate bill 1679 and our opposition to Senate bills 1456 and 1581, together with some of the supporting reasons for this position.

The views that I present are not just my own. They represent the views of the American Federation of Labor as they have developed in conventions of our organization and by the social security committee in the discharge of obligations placed upon it by convention action.

It was more than 10 years ago that the American Federation of Labor first adopted a resolution supporting national compulsory health insurance. This was in 1938. Similar actions were taken by the conventions of 1939, 1941, 1942, 1944, 1946, and 1947.

The executive council of the American Federation of Labor, meeting in August 1948, reported to our sixty-seventh convention in part as follows:

> One of the major gaps remaining in our social-insurance program is its failure to provide for the costs of medical care. We know that about a third of the cases of public dependency arise through instances where through no fault of their own, workers have had to meet serious medical costs for themselves or members of their families that they were unable to pay. We have no desire to "socialize" the practice of medicine, but we agree that it is entirely feasible to spread the risk of the cost of illness by application of the compulsory insurance principle so that no worker need to labor under the constant fear of disastrously high doctors' and hospital bills.
>
> Meantime the interest and demands of our membership and of people generally for providing for the costs of medical care through insurance continue to grow. The failure of Congress to act has not prevented many of our unions from providing some protection through collective bargaining. While this method is the best available at this time, we recognize that it is not as sound nor as practical as the comprehensive program envisaged in the Wagner-Murray-Dingell bill (S. 1606).

Of course, you recall this was a report made last August.

The sixty-seventh convention met in Cincinnati in November and in addition to adopting this report of the executive council unanimously adopted the following declaration on health insurance:

> A comprehensive program to provide and meet the costs of medical care and service by the extension of social insurance should be established. Such program must preserve the individual rights of both patients and physicians. The program should include provision for an extensive program for the construction of hospitals and health centers, the training of medical personnel, and development of research.

This declaration has a somewhat different emphasis than earlier convention actions. It does not represent a retreat from earlier stands on the subject of health insurance but a step forward. The new emphasis is on recognition of the necessity for a comprehensive program which includes the training of medical personnel and development of research and in which health insurance is the keystone of the arch.

The Cincinnati convention also directed the social security committee to work out in more detail the standards applicable to such a comprehensive health program. This was done in January of this year. The committee reported the detailed specifications of this program to the executive council which met in February. The executive council adopted this program in full.

Just this month the executive council which has the authority of the convention between convention sessions held its second quarterly meeting of this year in Cleveland, Ohio, and it voiced its specific approval of Senate bill 1679 and opposition to Senate bills 1456 and 1581.

We note that there no longer seems to be a question as to the need for a different method available to the great mass of our population for meeting the costs of medical care and services. Ten years ago when our organization first espoused the cause of compulsory health insurance the opposition forces claimed that there was no need for any change in the method of payment. They have since shifted ground. The high and unpredictable cost of medical care is recognized. Even the most outspoken opponents of national health insurance now admit that there is a need for a new method for meeting the costs of medical care and we find them warmly espousing the programs which only a few years ago they labeled as "socialism and communism—inciting to revolution."

The hearings of the subcommittee on wartime health and education and on the various proposals that have been before the Congress in the last several years have served to establish the existence of this need beyond any doubt. The problem which confronts your committee now is that of determining the method by which this need can be met. The three major bills which are before your committee for consideration present two basic approaches to this recognized need. In addition, there is Senate bill 1106 which undertakes to meet one segment of the problem only. While the limited objectives of this bill appear entirely worthy I am not prepared to present a position with respect to it since our organization has never given consideration to this type of limited approach to the very large problem.

With respect to Senate bill 1581 we observe that it includes the defects which would be expected of a measure designed primarily as a substitute for a health-insurance program. It is a negative approach. We are opposed to it first because it is unsound to turn over the entire administration of any public program to one party at interest. This bill does that with a vengeance all the way from requiring that the director shall be a physician to denying any effective participation at any level of administration to the representatives of those who would have to pay the costs of the program.

The most serious deficiency of this bill is that it fails completely to meet the health needs of working people. The people whom I represent and who have consistently asked for health insurance are the self-supporting, employed working people of the middle-income group. They are constantly confronted with the problem of how to meet the high costs of medical care. This bill does nothing for them. In order to be eligible for benefits under this bill a person would first have to be certified as needy after investigation of his finances. This is repugnant to the American working people and will never be accepted by them as a substitute for health insurance.

I submit as the most damaging indictment of this measure a statement by its principal sponsor made in Pittsburgh on February 19, 1949. Referring to the dangers of the "means test," he said:

> Unquestionably it does deprive the recipients of charity of some freedom, but as long as four-fifths of the people remain their own bosses there is no serious infringement on the principle of liberty for the entire people.

Senator TAFT. No, no, no; you misconstrue that. That is not what I said. Would you read the last sentence again?

Mr. CRUIKSHANK. It is all one sentence, sir. [Reading:]

> Unquestionably it does deprive the recipients of charity of some freedom, but as long as four-fifths of the people remain their own bosses there is no serious infringement on the principle of liberty for the entire people.

Senator TAFT. It is not the means test which deprives them of it. It is free governmental care that deprives them of their liberty. That is the misconstruction that you made of that statement.

Anybody who gets free medical care from the Government is deprived of his liberty. That is the point in my statement, because he gets what the Government gives him. He does not choose his own medical care. It is not a means test.

On the same basis I would say that the Murray-Wagner-Dingell bill deprives everybody of their liberty in that field, 100 percent of the people instead of 20 percent.

Mr. Cruikshank. It does not necessarily establish that it does.

Senator Taft. That is the point. If you will read my speech, that is what I said. My point is that the minute the Government gives you something you are deprived to that extent of liberty certainly, because you cannot choose your own.

Mr. Cruikshank. We maintain, Senator, that the Government does not give us this.

Senator Taft. But it is not the means test. That is not an indictment of the means test that you quoted. It is an indictment of giving free care to anybody under the circumstances. To that extent he is deprived of the liberty of choosing his own care. He is forced to pay the tax, and then he gets what the Government gives him, not what he wants to choose.

Mr. Cruikshank. I submit that that is entirely a value judgment on the program.

Senator Taft. You may question what I say. I am only correcting what you say I said, which is not correct.

Mr. Cruikshank. The quotation is correct.

Senator Taft. The quotation is correct, but it does not mean the means test. You quoted it as an indictment of the means test. It is an indictment of free Government medicine for everybody, for anybody, or any free Government service, as far as that is concerned; to that extent a man has to pay the tax, he is deprived of the liberty of choosing his method of getting that service.

Mr. Cruikshank. It might under some circumstances, and under proper safeguards it might not. In any event, I think that the comment that immediately follows, Senator, is pertinent whether it is to the means test or to what you call free medical service.

The working people of America will never accept in this field or any other the principle that freedom and liberty are the rights of only those Americans who have the money to pay the price.

Senate bill 1456 embodies many of the deficiencies of S. 1581. The essential weakness of this measure is disclosed in the first section on declaration of purpose (section 701 (c)) "providing protection to persons financially unable to pay all or part of subscription charges for prepayment of hospital and medical care." We have seen no proposal for determining who those persons are who are described as financially unable to pay all or part of subscription charges. While the bill itself does not specifically provide a means test, leaving the standards of eligibility for such assistance to the State, the means test is inevitable. It would require an army of investigators prying into the private affairs of the beneficiaries in order to determine that they were unable to meet the rates charged by the so-called voluntary agencies. The very use of the phrase "all or part" indicates the minuteness of the examination into the private affairs of individuals that would be required.

Who is to determine and how is he to determine whether the head of a family is able to pay a part of the subscription charges? How is he to determine what part the individual is able to pay? How is he to determine at precisely what point a hitherto self-supporting family whose breadwinner is deprived by illness of the opportunity to earn his own support becomes unable to pay all or a part of the charges? How indeed except by prying into the personal affairs of this family.

Senator TAFT. You do not think that S. 1679 abolishes the means test, do you?

Mr. CRUIKSHANK. I do, yes; for the people who are covered by the insurance program, it certainly does.

Senator TAFT. Yes, but not of the poorest people. Many of the poorest people it does not, and many with very low incomes, it does not.

Mr. CRUIKSHANK. Senator, I would consider it highly presumptive on my part if I should attempt or undertake to coach you in the principles of social insurance, but your question indicates certain lack of understanding of the social-insurance principle.

Senator TAFT. What I want to indicate is this: That there are a large number of people who are not covered by social insurance. They will all be subject to the means test, millions, probably.

Mr. CRUIKSHANK. That is right.

Senator TAFT. So that I am pointing out that S. 1679 does not eliminate a means test. You are simply suggesting that the means test would be more extensive under our bill, that more people would qualify, would be unable to pay. I suppose that would be so, to some extent.

Mr. CRUIKSHANK. Here is the point, as I see it. Old-age insurance and survivors insurance, our basic social insurance program, does not abolish the means test because we still have public assistance. Unemployment insurance does not abolish the means test because it covers necessarily by nature a limited period of involuntary unemployment at the termination of which if a man has not gotten a job, he may have to fall back on the public-assistance program. Therefore, unemployment insurance cannot abolish the means test, but your whole insurance approach is like a net spread under acrobatic performers. Some may get caught on it and be saved; others may fall through the meshes of that net, and you have to have a basic underwriting that catches the people who fall through other screens.

Now you have that in any social-insurance program. You have it in old age and survivors, you have it in unemployment, but the difference is in your approach. Your approach, S. 1679, is to make the basic program a self-supporting insurance program where people, the larger masses of people, the self-supporting working people are covered by insurance, but we do recognize——

Senator TAFT. Not insurance.

Mr. CRUIKSHANK. Well, we say insurance, you say tax, so when you speak and you say tax, I substitute in my own mind insurance, and I presume that you do the opposite, but it is still a point of view.

Senator TAFT. On the means test, though, what you admit is this, I take it: The means test remains under social insurance, the same kind of means test. It is not quite as extensively used. If you have social insurance you do not have to subject quite so many people to it, is that it?

Mr. CRUIKSHANK. That is not quite what I say. I agree that you do have to have a means test for some people, but the basic difference is in the approach which is your major program, a program on the relief or hand-out basis, or a program on the insurance basis, and that I think is the essential difference.

Senator TAFT. That is not the major approach because you admit that your plan has an approach from a hand-out basis, too.

Mr. CRUIKSHANK. No.

Senator TAFT. Only you say not for quite so many people.

Mr. CRUIKSHANK. We do not admit that at all. We only say that the means test remains for the few who are not saved by the insurance system.

Senator TAFT. Not so few.

Mr. CRUIKSHANK. Relatively few. It might be millions, but relatively few in this big country.

Senator TAFT. You have, of course, a means test of public housing for the public-housing program.

Mr. CRUIKSHANK. You have an income test.

Senator TAFT. Everybody who wants public housing has a means test.

Mr. CRUIKSHANK. Not quite. It is not the same. You have an income test.

Senator TAFT. That is all you have under this bill. A means test today is nothing more than asking a man how much wages he gets. You investigate the words "means test." We say those who are unable to pay——

Mr. CRUIKSHANK. But that is the difference. People who are unable to pay is quite different from a simple determination of the salary. What do you do if his wife is working? What do you do if he has a son in the family who is unable to pay? That is quite different from the arbitrary income standard that is set for housing, do you not agree that it is?

Senator TAFT. No, I do not agree at all. I think it is the same question. You cannot let a man in if he has an income that is counted against him in housing; it is the same thing.

Mr. CRUIKSHANK. But you do not have to go into the matter of his savings——

Senator TAFT. Of course you do.

Mr. CRUIKSHANK. In housing?

Senator TAFT. Why certainly. It is his whole income. You mean can he use principal? I would not suggest under this bill we make anybody use principal.

Mr. CRUIKSHANK. I do not suggest it, but when you find a man is unable to pay, he may have a thousand dollars worth of war bonds. Is he unable to pay then?

Senator TAFT. I would be delighted to put that in if you want it, but I do not think the modern test of income contains it today. There was a time when it did. There is some provision in some of the old-age legislation which I would take out. In fact I am not sure that we did not take it out the last time.

Mr. CRUIKSHANK. No, you did not.

Senator TAFT. I would be very glad to do it. I would be very glad to put it in this bill, if that is all that bothers you. I will be glad to include that principal should not be considered——

Mr. CRUIKSHANK. There are many States where a person has to sign over ownership of the property before he can get public assistance. He has to sign it over to the State.

Senator MURRAY. That is true, in practically every State.

Senator TAFT. Only where they are old, is it not?

Mr. CRUIKSHANK. That is right.

Senator TAFT. Where it is taken over by the State.

Mr. CRUIKSHANK. That is right, but that is the means test in reverse action. I think if you could find a formula——

Senator TAFT. You have the same test in every general hospital today. People come in. They take them all. If they think the people can pay, they send a bill and try to collect.

Mr. CRUIKSHANK. Sometimes they do and sometimes they require a deposit.

Senator MURRAY. Or they require some of their friends to come and guarantee that the bill will be paid. I have seen that done very frequently.

Senator TAFT. As a rule in general hospitals they have to take the people who come in if there is any serious illness at all, and take a chance on collecting. I agree that they do not always collect, but still you have the means test today in every general hospital in the country.

Mr. CRUIKSHANK. Well, that is one thing we want to do away with.

Senator TAFT. I have not heard any great kick about it.

Mr. CRUIKSHANK. You do not get the same mail I do, I believe, Senator.

Senator MURRAY. You mean to say the rule now is that every hospital has to take patients that come in regardless of whether they are able to pay or not?

Senator TAFT. No, not every hospital; every general hospital, city hospital. Very roughly speaking they have to take the people who come in.

Senator MURRAY. Every hospital in the ordinary town and city in the country requires that the patients be able to pay or that someone guarantee that their bill will be paid. Of course, there may be some general hospitals in New York or in Cleveland or in some of these eastern cities where they have a hospital that is set up for the very purpose of taking care of people who cannot pay.

Senator TAFT. Not eastern cities, but practically every city in the country has a general city hospital where they take people who cannot pay, and most charitable hospitals take people who do not pay. However, that is within their power. Some do not.

Senator MURRAY. Well, if you mean these so-called poorhouses around the country which are called hospitals, of course that may be true. I know we have an institution out in my city of Butte, where I live, which we call the county hospital, but it is nothing but a poorhouse.

Senator TAFT. That is for chronic diseases, Senator. I think we have about a 50-million-dollar general hospital in Cincinnati that takes anybody in that comes in, and costs the city about $3,000,000 a year to run it; I think that is generally true of all cities.

Senator MURRAY. You may proceed with your statement.

Mr. CRUIKSHANK. The unrealistic character of this approach to the problem is revealed at a number of points. For example, section 713 (a) (10) provides that—

> determination of eligibility shall be made, insofar as possible, in advance of the need for hospital and medical care; that the individual shall not be identified as a person accepting assistance at the time of receiving care.

This one provision ignores two basic aspects of the problem. First, indigency is in many cases a result of illness with its attendant high costs and loss of income. While attempting to approach the problem through providing insurance and at the same time attempting to avoid the universal coverage that is attainable only through compulsory insurance, this provision departs from a basic concept; namely, that the insurance must be taken out in advance of the need. The wording of this section indicates a kind of vague recognition of the fact that you cannot make it possible to take out fire insurance after the building has caught fire and at the same time recognizes that the safeguard against this possibility will not always be possible.

Secondly, it fails to take into account that the so-called voluntary insurance plans offer only limited protection. Very few of them provide for the payment of the entire medical and hospital bill even in catastrophic illnesses. If the individual has been found to be in such financial straits that he cannot pay the monthly charges for insurance protection how is he to pay those additional costs which are not covered under almost all these plans now in existence without being "identified as a person accepting assistance at the time of receiving care"?

There are a number of other serious deficiencies in this bill.

It would subsidize private agencies with public funds. As yet unspecified amounts would be turned over to private organizations with no provision for public accountability for standards of service and of administration or for any public supervision to maintain standards or to require reasonable economy. While the organizations to whom these funds would be turned over are nonprofit organizations, there is no safeguard, for example, against their contracting advertising or other acquisition activities to profit-making concerns. There are at present also six States in which the approved medical-service plans operate entirely through a list of private-insurance companies. While the medical-service plans themselves are nonprofit, the insurance companies through which they operate are far from being nonprofit organizations. The bill provides no safeguards for the use of public funds in such activities.

At several points this bill recognizes that it fails to meet important areas of the medical problem but dismisses these problems by calling for studies and surveys. Section 713 (a) (18) requires that the State plan provide for a survey of existing diagnostic facilities.

Subsection 19 requires the State agency to make a survey of the facilities, services and financing for the care of mental, tuberculous, chronic disease, and other patients hospitalized for a long period of time.

The problem of distribution of medical personnel is met—or rather avoided—in the same manner. Subsection 20 requires a survey of areas in the State which are unable to attract practicing physicians and calls for recommendation on methods of encouraging physicians to practice medicine in such needy areas.

We submit that the essential need today is not for more surveys of the problem. Study after study has revealed that the real nature of the problem of the distribution of facilities and of medical personnel is related to there being an effective demand for the services the provide. Such an effective demand can be provided only through a comprehensive insurance system supplemented where necessary by direct aid.

In contrast to the timorous, half-hearted and in many respect ill-advised approaches to the problem set forth in these two bills, Senate bill 1679 presents a complete and comprehensive program to meet the health needs of the nation, resting on the firm foundation of the proven principle of contributory social insurance. The health insurance program established in title VII of this bill is based on the principle that people should pay their way in proportion to their means, in this case by small regular payments into the insurance fund, and should therefore have needed medical services as a right not as a Government charity. This is an economically sound approach and consistent with our American principles and in line with the desire of every true American to maintain himself in decency and self-respect.

This program provides insurance against the cost of medical care for practically everyone. It provides for sound administration with proper representation from those who pay the costs and receive the services. It would be administered with Federal, State, and local participation with emphasis on local responsibility. While compulsory in terms of coverage and requirement for contributions it preserves the freedom of individuals to choose their own doctors and respects the freedom of doctors and hospitals to accept or reject patients. We submit that of the three proposals this is the only practical one. It is practical because it has taken into account all the many phases of the complex problem of providing medical care and services.

There are those who agree with the principle of comprehensive health insurance but who would tell us that it is impractical now because there are not enough trained professional personnel. This bill does not deny the need for training additional doctors and other medical personnel. The answer to those who say that we cannot have a health insurance program because of these shortages is found in title I where an adequate program of Federal aid to medical education is provided. It meets the needs of the medical schools, the dental schools, the schools of dental hygiene, schools of nursing, schools of public health, and schools of engineering.

Another provision of this title provides direct assistance to qualified students training for service in the medical field. Since the costs of modern medical education are necessarily high, under present circumstances very few can enter the field except the sons and daughters of the rich. Students of medicine and allied fields should not be selected on the basis of the financial means of their parents. When this program has been in effect for some years we look forward to there being not only more doctors, but more doctors who understand the problems of working people as some sons of working men would then have a chance to enter the profession.

There are others who say that the method of payment provided in a health-insurance program does not meet all of the problems because there is much work to be done in the field of medical research. We have never claimed that health insurance alone meets all of the needs. The need for additional medical research in the diseases which so far have baffled even our advanced medical science is recognized. The answer to those who would have us wait for the further development of research is found in title II, where aid to such research is provided, through the setting up of continuously financed institutes of research in special fields.

While I recognize that title III of S. 1579 is not specifically before this committee at this time, one aspect of it bears so directly on the program envisaged in title VII that I ask the permission of the committee to comment briefly on this interrelation.

In March 1946, testifying on behalf of the American Federation of Labor before a congressional committee in support of the Hill-Burton Act, I presented the following statement:

> It is not only possible but entirely likely that the areas showing the greatest needs for health facilities will also be the areas where it will be most difficult to provide funds necessary for the operation of such facilities. We feel therefore that this program will be incomplete until there is some provision for funds for maintenance and operation.
>
> The position of the American Federation of Labor is that the soundest method of providing funds for the operation of health facilities is through a national system of health insurance as proposed in President Truman's health message to Congress.

While notable progress has been made under the operation of the Hill-Burton Act toward meeting the need for more hospital facilities we note that seldom has any prophecy been more clearly borne out than the one we made 3 years ago. The report presented to the Federal hospital advisory council at its last meeting in November 1948 showed that the State plans which had been submitted under the act showed a need for 865,682 new hospital beds—almost doubling the number of approved beds in existing facilities. Under the program operation for the fiscal year 1948–49, 467 projects for general hospitals had been approved. These provide a total of 23,327 beds.

Startling facts are revealed, however, by a study of the distribution of these projects by categories of need. These categories are set up under terms of the act in relation to priorities from A to F. Out of the 467 total approved projects only 253 or 54.2 percent were in A priority, corresponding to the areas found to be in greatest need. In terms of the number of beds in approved projects 10,691 or only 45.8 percent of beds are in the areas of greatest need as against 12,736 beds approved for areas of lesser need. In the State of Alabama there are 9 approved projects but only 1 having an A priority and that a small one of 82 beds. This is 8.3 percent of the total of 981 beds approved for that State. Other States representing recognized areas of need show a similar type of distribution.

This again points out there is a vicious cycle operating in the whole health field. Illness follows low income and is related to lack of facilities; low income in turn leads to a higher rate of illness and results in further lack of facilities. This vicious cycle must be broken by a concentrated united front attack on the whole problem. The program of health insurance contemplated in title VII of S. 1679 would provide the means for paying for the use of the facilities that are contemplated in title III and which are also proposed in Senate bill 614 and in title IV of S. 1581. While we do not recommend that capital expenditures be made out of the insurance fund and this need is met by the liberalized proposal for grants-in-aid under title III, it is in title VII that the all important problem of funds for operation of these facilities is met. It is not met in any other proposal which is before your committee.

Senator TAFT. Why not? That is just exactly where the money is going, the $300,000,000 a year we are giving the States is to go for the support of those people who are unable to pay for medical care and presumably will go to a large extent to the hospitals in the poor districts.

Mr. Cruikshank. It does not meet it on anything like the comprehensive scale or approach.

Senator Taft. That is true, but then maybe $300,000,000 is enough for that particular purpose. These are areas where the people are simply unable to pay for medical care. Therefore hospitals cannot be supported.

The money we give in our bill goes to those people and they are able then to pay for it and support the hospitals in those areas, or the State is authorized to buy voluntary insurance for them if they want to, or provide it in some way or pay the hospitals directly for their care, if they want to. It is just a question of the amount. Is $300,000,000 enough?

Mr. Cruikshank. I think you will find that $300,000,000 was not anywhere near enough.

Senator Taft. Incidentally, in these rural districts, you will get very few people who will qualify under the Murray-Wagner-Dingell bill. Most of the poor people there will not qualify at all, and there will not be any support therefore for their hospital care out of the insurance.

Mr. Cruikshank. There are other provisions of the bill, however, that relate to that.

Title V of S. 1679 offers further evidence of the practical nature of this comprehensive program. It does not call only for the survey of the special problems of rural and other shortage areas, but provides a program of action. In response to the recognized needs for additional personnel and facilities it provides grants or loans guaranteeing income to doctors and dentists and others who would practice in such areas. It meets such practical problems as the costs of travel for such persons and their families who are willing to respond to these needs. For those areas of sparse population mobile clinics and ambulance services are provided. There are also loans to supplement inadequate local funds for construction and grants for the maintenance of hospitals, group practice units, health centers, clinics, diagnostic and treatment centers. We recommend such a program in connection with the original Hill-Burton Act and experience under that act has likewise proven the practical need for such supplemental aid.

Part B of this title is in accord with our long-established policy that groups such as labor unions and cooperative organizations who establish adequate medical service plans should be encouraged and should be permitted to continue in operation as service agencies under a health-insurance program.

We commend the enlarged program for aid to States for maternal, child health, and crippled children services, provided in title VI. The American Federation of Labor was one of the national organizations that sponsored the creation of the Children's Bureau. Through the years the position that the Children's Bureau has always taken with respect to the welfare and health of children has been one activated only by a concern that the conditions under which children live and grow shall be the best. The Bureau has shown courage and leadership in carrying out its functions in the interest of all children.

This position is supported by the following action of the Sixty-seventh convention of the American Federation of Labor:

> We believe that all children regardless of race, residence, or family income have the right to whatever health and welfare services and medical care they need for wholesome growth and development and that is the responsibility of the Federal Government to help the States and communities meet these requirements. We favor raising the amounts available for payments to the States to whatever sum is needed to meet the requirements of an adequate maternal and child-welfare program.

The American Federation of Labor fully supports Senate bill 1679 in its entirety as it is the only proposal which has been brought forward which provides a way by which the American people through their Government can meet the many-sided problem of providing for their health needs and we urge favorable action on the measure by your committee and by this session of the Congress.

Senator MURRAY. Mr. Cruikshank, I understand that the A. F. of L. engages in extensive bargaining with employers with the view of securing the kind of medical care and hospitalization that they need. Would they consider that a complete and sufficient answer to the problem of medical care?

Mr. CRUIKSHANK. No, Senator, they would not. As nearly as we can tell now—it is a very difficult statistic to work out—in our unions there are somewhere between a million and a million and a quarter people who are covered with some kind of health-insurance program under collective bargaining. There are only two or three centers, however, in the United States where they can get anything like complete coverage. One is in New York and there is another in St. Louis.

As I say, there are very few centers. Most of them include in collective bargaining some of the coverage under Blue Cross, and some of them under cash indemnity programs with private insurance carriers, some under the medical service plans, but all of these have such limitations.

Well, it is quite interesting to us to note that some of the strongest representations and the support for compulsory health-insurance programs come from the unions that have the present inadequate coverage. Their experience with them is not satisfactory.

Senator TAFT. It is fairly hard to work out a coverage in a thing like the building trades, it is not, I mean the contractors are so scattered, they come and go?

Mr. CRUIKSHANK. Quite correct; yes, sir. You have to have for that kind of protection a combination of circumstances such as a relatively immobile type of labor such as you have in the mines or you have largely in the needle trades, or lacking that, a large metropolitan area where the shifts between employers are absorbed and the agreements are made with an association of employers such as the Government workers of New York City, and then of course you have to have strong bargaining power.

Where you lack either of those factors—now in the building trades you have strong bargaining powers, but you lack the other factor. Therefore the building trades unions are among the strongest supporters of compulsory health insurance because it was the only way that these transfers could be automatically worked out.

Senator MURRAY. In New York they have an insurance system that many members of the A. F. of L. belong to, the greater New York Insurance plan, I believe they call it.

Mr. CRUIKSHANK. That is right, yes.

Senator MURRAY. How does this plan work out so far as the workers are concerned?

Mr. CRUIKSHANK. Well, that works out quite satisfactorily. There you have a large metropolitan area. You have the health facilities available. The health insurance plan of greater New York now has contracts with I think 26 group health units.

You have even with the building trades the flucuations contained pretty much within the metropolitan area, so that some of our building trades unions like the painters have gone into the health insurance plan, hotel and restaurant workers and others, and there you have a quite comprehensive complete program of medical care.

The only program of medical care that I know of where the coverage corresponds to the coverage contemplated in S. 1679 is in that plan, or corresponds very closely to it.

Of course that is a new plan, but so far their experience has been quite satisfactory with the health insurance plan of New York. It is costly. It cost a lot of money to start it. I understand that about $750,000 was put in by private endowments to prime the pumps of that plan, and to get it so that it is almost impractical to think of that kind of a program working outside of perhaps San Francisco, Chicago and New York.

Senator MURRAY. Do any other cities have a similar plan?

Mr. CRUIKSHANK. There is no city that I know of where there is a plan anything like as comprehensive as the H. I. P. plan in New York. St. Louis has a plan that is quite comprehensive, but does not go as far as the H. I. P. plan, and it is a health-center plan for a number of units rather than a contracting plan for services of group-health units as the plan in New York is.

Senator MURRAY. Under the Government's program of medical insurance, there is considerable propaganda today in the country to the effect that this will take a too large slice out of the pay check of the workers. What is the attitude of the workers in regard to that?

Mr. CRUIKSHANK. Our unions have consistently supported the contribution system in the social insurances. In old age survivors insurance, it was interesting to note the resolutions that came in at the convention in Cincinnati last fall. As many resolutions came in for raising the contribution rate as came in for increasing the benefits. I think that indicates that our membership is quite well aware of the fact that you do not get something for nothing in any of the social insurances.

The resolutions that come in from cities, States, and the national conventions almost invariably carry the recognition of the necessity for the pay-roll deduction. Our people recognize that this would not be a net reduction in income; that it would take money out of the pay envelope as it comes in, but that it actually would represent a saving in expendible wages.

Senator MURRAY. The A. F. of L. has been interested in this problem for a great many years, as I understand it. They started agitation for a program of this kind some 10 or 12 years ago, is that not true?

Mr. CRUIKSHANK. That is right; yes, sir.

Senator MURRAY. At that time their proposals were considered extremely wild and socialistic and communistic, as I understood you to say in your statement, but that attitude is completely changed in the country today. Now it has come to be recognized that there is a serious need for some program to meet the problems of the great masses of our people in regard to health care.

Mr. CRUIKSHANK. I think that is very true, Senator, and we believe that we discern, and we believe we discovered we are pleased, there is less talk about socialized medicine and socialistic approach than there was 2 or 3 or certainly less than there was 7 or 8 years ago. I mean the people who differ with us on the method of meeting this believe the public has come to accept our proposal as not being a socialistic approach——

Senator MURRAY. And the very proposals that are offered instead of it are socialized programs themselves.

Mr. CRUIKSHANK. Quite true, they are much more socialistic in their concept and approach, unwittingly so, than our approach.

Senator MURRAY. And will more likely result finally in a complete socialized system of medicine in this country.

Mr. CRUIKSHANK. I am quite sure they would. In fact we have had that experience for a long time. I am sure that Senator Taft will remember this.

I was raised in Ohio and my earliest recollections of any social program is the blasts that we used to get in the newspapers that were delivered to our home about the socialistic approach of workmen's compensation in Ohio.

Well, we stuck with it, and I do not think anybody calls workmen's compensation socialistic, and I hope that the Senator and I will both live to see the day when this will be accepted just like workmen's compensation is, and the bogie of socialism is long since buried.

Senator MURRAY. I notice by the press this morning that the Republicans have offered a new bill or program of medical care. Are you familiar with that?

Mr. CRUIKSHANK. Only what I see in the press, Senator. I read the reports in the New York Times this morning.

Senator MURRAY. You would not be able to discuss it at this time?

Mr. CRUIKSHANK. No, I think it would not be appropriate for me to discuss it. I have some ideas, but they are purely my own. I would have to submit that to our committee and the policy makers in our organizations.

Senator MURRAY. Well, as I understand it, it has been developed as a result of the agitation that has been going on in the country for the last 10 or 12 years, and that it goes much further than any program yet offered by the opposition to the national health insurance program.

Mr. CRUIKSHANK. As I understand it that is quite true, Senator, and it is quite cheering to find that there is an approach suggested there that avoids the whole needs basis, if I understand it correctly, and still proposes, I believe, to work through the existing voluntary insurance agencies, but not to do it on the basis of proven need.

Now I had better not comment any further on it because, as I say, I have only seen the newspaper reports on it, and it has not been submitted to my social-security committee, and we have no official position on it.

You asked about this health insurance plan of New York. I have here some charts which they prepared which show the relative costs and the relative coverage of the United Medical Service in New York, and the insurance plan, and also some comparisons between the group health insurance in New York and the health insurance plan.

The costs are considerably higher for the health-insurance plan. For example, the monthly charge is $7.25 for a family of three or more persons in the health-insurance plan, as against only $1.80 for the united medical service, but then when you look into the provisions of the coverage you find—I will not go into them in detail here, but there are 17 important excluded items. That points up the problem.

If you have a program that is inexpensive enough to be within the reach of the ordinary person, you have the risks that you want to cover excluded, and if you extend the coverage to include the risks with which working people are actually confronted, then the cost goes up to the point on a flat-rate basis where it is beyond the reach of the person of average income.

Senator TAFT. Who pays for it? Who pays the difference?

Mr. CRUIKSHANK. In which plan, sir?

Senator TAFT. In the low-rate plan. Somebody must pay for it.

Mr. CRUIKSHANK. Well, in our proposal it is rated on a percentage of income so that it becomes a social insurance.

Senator TAFT. But it is generally agreed for instance that the cost of medical care is $100 a family at least throughout the country. In fact, the Murray-Wagner-Dingell bill contemplates more than that, $6,000,000,000 over 40,000,000 families. That is $150 per family. Who pays the difference? Where does it come from if you pay $1.80 a month per person?

Mr. CRUIKSHANK. Well, first let me say that it is just not the difference between $1.80 and the $7.25. These people have to dig into their pockets for the costs against which they are not protected. They have to do without all kinds of things, and society pays for it. For example, if a worker has to take his child out of school in order to pay that difference, society pays it.

Senator TAFT. I thought you said $1.80 was UMI.

Mr. CRUIKSHANK. The $1.80 is United Medical Service in New York, yes, but there are 17 exclusions of important risks.

Senator TAFT. That is a private plan for just certain things?

Mr. CRUIKSHANK. That is right.

Senator TAFT. Even hospitals, because hospital-insurance costs around $3 a month for a family, does it not?

Mr. CRUIKSHANK. Yes, that is right. The hospital alone would cost more than $3.

Senator TAFT. Senator, Senator Donnell and I would like to question Mr. Cruikshank. I wonder if Senator Lodge would be permitted to make his statement.

Senator MURRAY. Yes. We will continue with Mr. Cruikshank after Senator Lodge has presented his statement.

STATEMENT OF HON. HENRY CABOT LODGE, JR., A UNITED STATES SENATOR FROM MASSACHUSETTS

Senator LODGE. Thank you for this opportunity to appear with reference to S. 1106. This bill embodies a thought which I have cherished for a long time and which I first advanced in a different form back in 1940, reintroduced in a quite different form in 1947, and to which I subsequently made further revisions, as I received criticisms and suggestions from interested parties.

Let me say at the outset that this bill does not pretend to be a panacea for all ills, or to be a comprehensive approach to the subject. It is a limited and practical approach which I believe could do a great deal of good in a very direct way. It is perhaps something which could be quickly enacted at this session whereas the rare, complicated, and far-reaching schemes certainly cannot be. Of course, the bill which I propose is in no sense of the word a substitute for these comprehensive insurance schemes.

This bill seeks to provide certain free medical services and drugs to needy people. There are at present a considerable number of medicines and drugs the manufacture of which has become thoroughly standardized and which are properly regarded as specific remedies for well-defined diseases. These particular medicines, unlike the majority of medicines, are so expensive that they are beyond the reach of many persons. For example, big hospitals will make gifts of small quantities of most types of medicines. For these hospitals, however, to give away the medicines to which this bill refers would strain their finances to a point which they could not bear.

Some of the drugs and medicines which fall into the category of being utterly necessary but quite expensive are: (1) Sulfa drugs—these are used now for many illnesses, including pneumonia, streptococcus infections, and other types of infections; (2) insulin—which is used for diabetes; (3) liver extract—used for pernicious anemia and occasionally for other anemias; (4) mercury diuretics—used for patients with congestive heart failures; (5) endocrine products—most of these except thyroid gland are expensive; these are used for glandular and nervous disorders; (6) vitamin preparations—thiamine chloride, nicotinic acid, viosterol, vitamin K; these are used for a variety of conditions, but especially for nutritional deficiencies; (7) typhoid vaccine used to prevent typhoid fever and already is compulsory in some States; (8) penicillin and streptomycin—used in the treatment of a variety of infectious diseases.

The above list is, of course, by no means complete, but gives you an idea of the type of drug and medicine which I have in mind. The same philosophy, of course, carries over into the field of medical services. There are a number of diagnostic services and remedial treatments which in many cases are utterly necessary for health and even for the preservation of life, but which, because of their cost, are in many instances beyond the financial capacity of many American citizens. Among these services would be the use of respirators, the so-called iron lung; and, very conspicuously, large-scale X-ray facilities. I believe that it is not disputed that countless instances occur every day in which X-ray examinations are desirable—yes, even essential—but they are not given because of the prohibitive cost. The same is true of other services necessary to diagnose obscure or difficult illnesses. Complicated and expensive procedures are often necessary for even the most qualified physician before he can capable, reasonably, and certainly diagnose the trouble.

An unestimated number of people every day are forced to do with less effective remedies, whether by way of medicine, services, or diagnosis, for the simple reason that they cannot afford them. The effect of this situation on the health of the Nation is too obvious for extended comment. This bill seeks to meet this issue.

S. 1106 is definitely not designed to provide a complete Federal subsidy for free medicines and free services for all diseases. In this bill, I have attempted to be selective and to restrict it to those drugs and services which fall into the categories just described. The health problem in this country is far too vast and far too complicated to solve all at one time. You have to do it piecemeal. Last year I appeared before a subcommittee of this committee with reference to a bill providing certain medical services for school children. This year legislation of this type has already passed the Senate. That is one piece of the whole picture. The bill upon which I testify today is another piece—but a very important one.

Now to the bill itself. Fundamentally, as stated in its title, the bill amends the Public Health Service Act so as to provide assistance to the States in furnishing certain medical aid to needy and other individuals.

(*a*) The sums to be made available under this bill are to be used for making payment to States which have submitted plans for furnishing medical aid. These State plans are to be submitted to and approved by the Surgeon General of the United States. This approach is similar to that used in other legislation on the general health question.

(*b*) The State plan for furnishing medical aid must meet certain standards:

(1) It must provide that the medical aid will be available to all political subdivisions of the State;

(2) It must provide for financial participation by the State;

(3) The State plan must also provide for the designation of the State health agency to administer the plan.

This provision together with several others, was inserted in the bill at the specific recommendation of the Surgeon General. When I first introduced this bill, the Surgeon General was kind enough to give it his very careful study. As a result of that study, he made many constructive and helpful criticisms which I will mention from time to time as I come to them here in the bill. I might also add that many changes in this bill were suggested by experienced private practitioners.

(4) The State plan must also provide that the State health agency will make the necessary reports from time to time to the Surgeon General and that the State health agency will comply with such provisions as the Surgeon General may prescribe regarding these reports;

(5) Lastly, the State plan must provide that the administration within the State will be on a merit basis subject to regulations promulgated by the Surgeon General must approve any State plan which fulfills these five conditions. He will not, however, approve any plan which imposes as a condition precedent to receiving aid under

this program a residence requirement denying aid to any person who has lived in the State for at least 3 months. This provision was incorporated at the suggestion of the Surgeon General.

(*d*) Regarding the financial aspect of this program: Once the State has its plan approved by the Surgeon General, the Secretary of the Treasury is authorized to pay to the State an amount equal to one-half of the total amount expended by the State during each quarter under the plan. Before each quarter begins, the Surgeon General estimates the amount to be paid the State for the quarter. This estimate is based on: A report filed by the State containing its estimate of the total sum to be expended and, on such other investigations as the Surgeon General may find necessary. In other words, this is the common sort of "matching funds" financial arrangement. The Surgeon General then certifies to the Secretary of the Treasury the amount which he estimates the State will need, making necessary adjustments for greater or lesser amounts as the circumstances warrant. Again, I believe that this follows the convention arrangement.

(*e*) There follows in the bill a section which provides for termination of assistance where any State fails to meet the minimum standards provided for in the bill.

(*f*) Section 705 of the bill, which appears on page 6, lines 7 through 17, was added at the suggestion of the Surgeon General. Following a pattern set in the Public Health Service Act, this section gives the Surgeon General authority to prescribe necessary rules and regulations to administer the act, including, you will note, "the expansion or restriction of the services and drugs falling within the term 'medical aid' as defined in section 706." I will come to that in a minute. It is also provided, still following the pattern of the Public Health Service Act, that the Surgeon General will confer with the State officials before issuing any regulations. I understand that this procedure has worked out very satisfactorily in the case of programs in the past and programs now in operation, and I was glad to make similar provision for that procedure here.

(*g*) Section 706 is the heart of the bill. In that section, the term "medical aid" is defined, and medical aid is, of course, what is being furnished under this act with the assistance of Federal and State funds. By definition, the term "medical aid" means making available, free to such persons as may require the X-ray services, laboratory diagnostic services, and respirators, and any drug which is of substantial, accepted, and specific value in the treatment and prevention of certain named diseases or such other infections or chronic diseases as the Surgeon General may from time to time include in the list.

An excerpt from an editorial of last year in the New York Post, entitled "Night Cries," eloquently describes the pathos caused by the need which this bill seeks to relieve:

NIGHT CRIES

> A sudden cry in the night, the lights go on, the child is rigid with pain, screaming for help. Then parents think of the rare drugs—streptomycin, sufadiazole, and penicillin. The drugs with the tongue-twisting names which could spell out hope for their child's life. The drugs whose very mention is a benediction in most American households.
>
> But the mercy of these drugs is often stamped with a price. And the healing of insulin, liver extract, mercury diuretics, endocrine products, vitamin preparations, typhoid vaccine, X-ray, and iron lungs, in many cases must be bought.

Health in America is still governed by the dollar sign. Our rich have modern medical privileges and our poor, too often, have only a prayer.

You will note that these drugs and services are made available to anybody who may require them. I would like to comment briefly on this eligibility provision. In bills which I previously introduced, I had a provision that these drugs and services would be available only to needy persons. Obviously, they were the ones for whom this program was designed—the people who could not afford these expensive drugs and services. This provision, however, was universally criticized. It was felt both by the Surgeon General and by the many doctors to whom I submitted the bill for comment that restrictions of the aid only to the needy would require an elaborate means test, which would be difficult to administer and expensive to execute.

It was, therefore, suggested that eligibility under the bill be made available to any person who might require these drugs without reference to financial status. It is clear that restricting this program to needy persons would be difficult to administer and might possibly defeat the whole purpose of the program because of red tape. But the purpose of this program is solely to benefit people who can't afford the medical aid provided.

I understand that the question of confining medical aid to the needy versus making it available to everyone regardless of need is one which your committee confronts with regard to all this proposed Federal health legislation. I presume that eventually your committee, after a more careful investigation than I as one individual can possibly make, will pass on this question of policy. I shall cheerfully accept whatever determination the committee makes regarding need insofar as S. 1106 is concerned. For my part I want the help to get to those who need it and want the law to express this thought in the most effective way.

Still referring to section 706, you will notice that the Surgeon General is given authority to prescribe other infectious or chronic diseases for which these medical services and drugs may be furnished. This provision was also adopted at the suggestion of the Surgeon General. He felt that a certain amount of flexibility was necessary in order to make the list of diseases current and up to date. I feel sure that we can rely upon the sound judgment and discretion of the Surgeon General in keeping this list within reasonable bounds. Likewise, the Surgeon General felt that the definition of services and drugs covered by the bill is not and probably could not be made so precise as to avoid considerable areas in which differences of opinion might develop, with consequent uncertainty and a possibility of dispute. He suggested that the Surgeon General be authorized to list in regulations from time to time those services and drugs which he finds to be within the definition, and that payments to the States be limited to services and drugs so listed.

In other words, this bill gives the Surgeon General quite a full amount of discretion with regard to the expansion or the restriction of the services to be rendered. At the same time, however, the bill sets forth enough specific services, drugs, and diseases to form a reasonably certain standard for the Surgeon General to follow. It is clear that the drugs and services to be provided are those which are effective yet expensive. It is likewise clear that the diseases for which they are to be furnished are certain chronic and infectious diseases which are unfortunately quite prevalent throughout the country.

(*h*) Lastly, the bill provides that the word "State" means the several States and the District of Columbia. It might well be desirable to amend the bill by including the Territories and possessions in it.

With regard to the cost of this bill I asked the Public Health Service to furnish me with an estimate and I received the following report from them last year relative to S. 678 of the Eightieth Congress which is identical with the pending measure, and I quote:

> Because of the number of variables involved it is impossible to make anything but the most approximate estimates of the cost entailed by the provisions of S. 678. The following paragraph gives such an estimate:
>
> "If it is assumed that 20 percent of the population would receive need of benefits under the provisions of S. 678, a tentative estimate indicates that the annual combined Federal and State expenditures for certain expensive drugs such as penicillin, streptomycin, insulin, liver extract, dilantin sodium (for epilepsy) and hormones, might amount to $23,000,000; and for expensive diagnostic services, such as X-rays, electrocardiograms, tissue culture, spinal fluid examinations, the expenditures might amount to $47,000,000. Of this total, $70,000,000, the Federal share would be $35,000,000."

Clearly, this cost is not prohibitive at all in the light of the benefit to be gained.

In conclusion, let me say that this measure would not regiment. In all cases the initiative would rest with the individual. He himself would choose his own doctor and his own hospital, who would, of course, have to be licensed to practice under State law. The Federal Government would merely give full recognition to the work of private enterprise, and simply set up the machinery whereby help of known and certain value would be extended. There is no guess work in this program; it is of proven worth. Questions of medical personnel and hospital standards would remain where they are now, in the devoted hands of professional physicians under State law. The part played by the State and local governments is recognized and enhanced.

There is to be no setting up of a bureaucracy or of any other obstacles between the patient and his health. No promises are made which cannot be kept. This scheme is as direct as a governmental scheme can be. It provides specific, concrete, definite aid for diseases. It is believed that in giving everyone a chance to have these medicines and services very great good can be done.

In recent years we have taken important steps looking toward the establishment of a well-rounded, integrated social-security program. Workmen's compensation for many years has provided financial aid to those who have suffered from injuries sustained during the course of their employment. Unemployment compensation aims to protect the unemployed from loss of wages. Old-age pensions are being developed which will safeguard our people from the hazards of insecurity. Well-conceived health measures should bring measurably nearer the day when the American people will be as physically fit as is humanly possible.

This bill is a humble first step toward this inspiring goal. It is, I think, in harmony with the doctrine which should animate all social legislation in America; that it fills in those chinks which our competitive economic system (on which our greatest dependence must always rest) does not reach.

Senator Murray. Thank you very much for your statement, Senator. I think you have spent a good deal of time in preparing this program. It sounds very practical.

The only thing about it that I would fear would be that it would be so attractive that there would be a demand to extend it to the whole country, to the whole population, and as you say in your program here:

> It was therefore suggested that eligibility under the bill may be made available to any person who might require these drugs without reference to financial status.

Do you not think that in the course of time there would be a widespread demand to extend that through the country?

Senator Lodge. Well, I think that if you help people to get the things that really constitute a big problem for them, that you will do an awful lot. Of course, there are some people for whom any form of expenditure is a problem, but most people can get bicarbonate of soda and things like that.

It is these very expensive medicines and diagnostic services that are a tremendous obstacle, and I think if you take, for example, the question of X-ray, what that can mean in the life of an individual and how many people are denied the services of X-ray diagnostic facilities— I think if you were to eliminate that obstacle, that you would be doing a great deal.

Senator Murray. Yes. Of course the American Medical Association has discovered that practically 80 percent of the population is unable to meet the costs of serious illness, so that there is a very large proportion of our population that would like to avail themselves of this program that you suggest here, and it would be practically an extension of socialized medicine to the whole country.

Senator Lodge. Well, I do not know what the words "socialized medicine" mean. That is one of those phrases that gets bandied about. Everybody can define it to suit himself.

This certainly does not promise anything which it cannot deliver. This does not interfere with the standards of the medical profession. It does not guarantee things that you cannot guarantee. This is confined to packaged definitely identifiable, definitely proven remedies. There is less guesswork in this than there is in some of these schemes, although I admit, as I said at the outset, that it is limited in major.

Senator Donnell. Might I ask the Senator a question? Senator, I think I get your idea of the development of this bill, but I am not quite clear as to some of the statements in what you have submitted here this morning. For instance on page 1 you say:

> This bill seeks to provide certain free medical services and drugs to needy people.

You get over to page 2 and say:

> An unestimated number of people every day are forced to do with less effective remedies, whether by way of medicine, services, or diagnosis, for the simple reason that they cannot afford them. The effect of this situation on the health of the Nation is too obvious for extended comment. This bill seeks to meet this issue.

A little further on you say:

> S. 1106 is definitely not designed to provide a complete Federal subsidy for free medicines and free services for all diseases.

Now notwithstanding the fact that you make the statement:

> This bill seeks to provide certain free medical services and drugs to needy people—

and that—

> This bill seeks to meet the issue of answering the problem of people that cannot afford these various medicines—

I understand that you have now gotten away from the idea of requiring need as a requirement and that you have adopted the view that anybody that wants any of these extraordinarily expensive medicines and services may get them.

You say:

> You will note that these drugs and services are made available to anybody who may require them.

Now I would like to know which of these two concepts is really the concept in this bill. Is it the needy requirement that is emphasized in several places in the statement, or is it the fact that you have gotten away from that and now find that these drugs and services are made available to anybody who may require them? Now which is the theory of this bill?

Senator LODGE. I would like the people who need these drugs and services to get them. I do not want to give them away to John D. Rockefeller or Henry Ford. I said on page 6 that this whole question of establishing the financial criterion of distributing medical aid is one which this committee is confronted with in regard to all this legislation, and you as a group with all the staff facilities you have got, the experience and the study you can give it, certainly know much more about that phase of it than I do.

I just heard a discussion this morning between Mr. Cruikshank and Senator Taft on what was meant by the means test. Apparently there is a difference of opinion as to what those things mean, and it gets into a very technical field.

What I want to do is to get these things to the people who need them, and in the most effective way. I want to fire a rifle, not a lot of buckshot all over the wall. That is what I want to accomplish, and I think you gentlemen, with all the experience you have got on the subject, can certainly work that out better than I can.

The heart of this bill is the expensive definitely proven medicine and diagnostic service. Now the method, I have changed that several times, and I am willing to change it again if you can find a better provision.

Senator DONNELL. In the earlier part of your statement you showed the earlier processes of your reasoning, namely that you were confining these things to needy people, but finally you got over here on page 5 where you say:

> You will note that these drugs and services are made available to anybody who may require them.

Now I do not see anthing in your bill here that would exclude John D. Rockefeller or anybody else.

Senator LODGE. No, there is not. I had the other way first and everybody that I sent it to disagreed with it and said it was unworkable, would make red tape and expense. All the doctors said it, the Surgeon General said it. I realized that that was out.

Senator TAFT. It would be up to each State. They would be limited to a certain amount of cash, and I take it that they could submit a plan to cover only those in need or could cover anybody if they wanted to, as I read the bill.

Senator LODGE. Yes; the States are given a lot of latitude in this respect.

Senator DONNELL. It seems to me that the development that has occurred in your own process with which you approached this bill is quite significant as indicating the fact that when you once start this sort of thing, you start it on perhaps a perfectly sound basis of providing something for people who need it, and then you begin to find all kinds of outcries like Mr. Cruikshank here and others against confining to those people, and then you extend it to the people who do not need it at all, and then you say to the committee:

> With your greater knowledge, tell me how to keep John D. Rockefeller from getting it.

Senator LODGE. I did not exactly say that.

Senator DONNELL. Then the further point——

Senator LODGE. Will the Senator permit me to respond to that first point?

Senator DONNELL. Certainly.

Senator LODGE. I have been working in this business for quite a few years.

Senator DONNELL. And you have not in all those years been able to figure out how to say "Yes" in one breath, and "No" in the other, have you?

Senator LODGE. I have not figured out all the answers to everything, no, I do not claim to. I have figured this out. If you have a proposition that appeals very much to you, it is not going to get anywhere unless you can make it appeal to somebody else, and when you get up a bill and everybody that you send it to says, "I like the part about the expensive medicines, but I do not like this means test," and all the doctors say that and the Surgeon General's office says that, why you know perfectly well you are licked before you start, so as a practical man you are trying to save what you consider the heart of the bill, then you shop around for some other method of doing it.

Senator DONNELL. But you do want to exclude people who do not need this?

Senator LODGE. I think it would be ridiculous to give it to Henry Ford and John D. Rockefeller.

Senator MURRAY. You would leave it to the discretion of the Surgeon General as to who would get the free medicines, is that it?

Senator LODGE. The States could have something to say about it. I would like to get the benefit of the committee's thinking. I understand that you are having a daily debate almost on this question of what the financial criteria are going to be. There are 13 of you here, and you have got all this high-powered staff that looks so intelligent sitting in back of you, and I expect you might all agree on something.

Senator PEPPER. I was about to observe that maybe Senator Lodge has a little more candidly phrased this dilemma than the advocates of some of the other plans have. That is exactly where they are going to come out one of these days, where he came out.

Senator DONNELL. May I ask a question along somewhat similar lines, and the question is this: While I fully appreciate the difference between quinine and streptomycin, nevertheless you have the same difficulty here, as I see it, in the bill, namely that you say the Surgeon General has authority to prescribe the rules and regulations, including the expansion or restriction of the services and the drugs falling within the term "medical aid." There is no limit in this bill. He can expand it as much as he wants or cut it down as much as he wants.

Senator LODGE. Last year you asked me whether he could not give him an overcoat because an overcoat stops you from catching cold, and therefore is beneficial to health. I remember that as your question.

That is the advantage of being a lawyer. You can think of all those angles. Of course anybody can abuse anything, Senator, that is the answer to your question, but the clear intent of this thing is to confine it very definitey expensive to medicines of proven value.

Now I suppose some scoundrel could get in there and give them overshoes and overcoats and everything else, but if we are going to write every law up here on the basis that the man who administers it is going to be a scoundrel, why we will never get anything done.

Senator DONNELL. I am not advocating writing it on that theory. Here is a thought, though, that I do have, and very seriously, and that is that where you have an act, a law here that gives a certain amount of discretion and gives elasticity and unrestricted rights to certain public officials, sooner or later you are faced with the fact, as I see it, that there is going to be a popular demand that whereas it was intended originally that this should be confined only to extraordinarily expensive things, that we ought to go and do what Senator Murray and Senator Pepper want to do here, namely to give medical treatment to everybody all over the country whether we need it or whether we do not.

Senator PEPPER. You do not mean give it to them. Ours is the one plan that makes them pay for it.

Senator DONNELL. That is just what I mean. I wanted to make that observation.

Senator LODGE. I do not believe in promising anything to people that you cannot give them.

Senator DONNELL. I think your bill differs in that respect from some other bills.

Senator LODGE. I am not going to talk about anybody else's bill. I think in this bill you do not make a promise that you cannot keep.

Senator TAFT. If you take care of enough of them, you may not have to engage in the general over-all plan.

Senator LODGE. That is quite possible.

Senator PEPPER. Senator Lodge, I would like to call your attention to this provision in S. 1581, introduced by Senator Taft and others, on page 16. This is a definition of a part of the content of the State plan which is to be submitted under that bill:

> Set forth a State-wide program designed and calculated to provide within 5 years medical and hospital services without discrimination to all those families and individuals in the State unable to pay the whole cost thereof.

Senator DONNELL. That is restricted to people who are unable to pay.

Senator PEPPER. The whole cost thereof.

Senator DONNELL. Yes; that is true.

Senator PEPPER. That would seem to me that the contributions would range from $1, perhaps $10, up to the whole cost of the services that might be required.

I think nearly all of us, most of us who have worked in this field, have found ourselves troubled by the same dilemmas.

I think practically all of us start off with the assumption that the present system is inadequate and that is no disparagement, certainly, of the best and most competent medical profession in the world, the finest hospitals, and all that sort of thing, but as things are at the present time people are simply not getting as many services and as much care and as many drugs, and I am certainly sympathetic to your approach here with these needy drugs as they require them for their health and life. You start off with that assumption.

I started off myself with the thought, what about the voluntary plans? I ran right into the dilemma in my own mind—in the first place a lot of folks never would join the voluntary plan. If you had a limited number of people in it, it would cost more. Then if you are going to adopt what I consider to be the theory of Senator Taft's bill, you will provide these services and this care to those who cannot purchase it themselves to the extent that they cannot purchase it, then you run right afoul of this means test. How are you going to decide all these distinctions between who can and who cannot pay for it, and who can pay some but cannot pay more, can pay more, but cannot pay all of the costs.

Then the next thing is if you start giving it to all those who need it, supplying the deficit as we supply the dollar deficit for some of our Marshall plan countries, if you start supplying the deficit out of public funds, Federal and State, the difference between what these services cost and what the people are able to pay, I cannot avoid the conclusion that you are going to run into an expense on the public treasury of certainly several billion dollars, and so then some of us got back to the conclusion, well, if you are going to start off with the hypothesis that you intend to fix up a system by which needed medical care, drugs and all would be available to the people of this country, if you do not attach the people of this country through the Federal Treasury with the expense of several billions of dollars, you are going to have to levy some kind of tax upon all the people that are brought within the coverage of the system, and simply let them pay on some percentage basis of their income.

Senator TAFT. We think our job can be done for $300,000,000, whereas yours is going to cost $6,000,000,000 according to the admission of the testimony.

Senator PEPPER. It is an amusing thing to me that the Senator from Ohio is going to fix up a system here that will give everybody all the services that they cannot pay for to the extent they cannot pay for it, and he is talking in terms of two or three hundred million dollars a year. That is like starting out with $10 to furnish a house. You simply cannot do it, and you have got to face some of these days one of two dilemmas.

You either are not going to be able to provide the people the difference between what they can pay for and what they need, or it is going to cost, out of the public treasury, several billion dollars, and the alternative——

Senator TAFT. I agree to several billion dollars, Senator, but you admit the fact that the cities and States are already spending most of it, that 80 percent of the people who cannot pay are getting free medical service today, and all we have to do if we are doing to keep the present system and not throw it away, is to fill up the gap and that is not going to cost over $300,000,000, if it costs that much.

Senator PEPPER. And that, of course, necessitates the use of the means test.

Senator TAFT. But the means test is just a term. It is perfectly easy. You have means tests for housing. Every man makes an income-tax return. It is perfectly easy to find out what his earnings are. That is just a bogeyman, the means test. We use it every day.

Senator PEPPER. Why does not the Senator write it in his bill then and leave it to administrative discretion? Then we will know what we are talking about.

Senator LODGE. You spoke about the Marshall plan, which I think is an operation that has been very free from scandal or graft, because in the case of the Marshall plan, for instance, the French farmer, if he wants to get a tractor, has to pay down French francs to get that tractor. That does not help the United States Government in the cost of buying the tractor, but it means the French farmer thinks very carefully before he comes in to get it, and he does not get 10 or 12, more than he needs, and sell them.

Now in that connection one of the prominent men in the ECA told me a story of going to a convention. A man was passing through the hotel lobby giving out these bottles of patent medicine for athlete's foot. The man took three or four of them and put them in his bag. His wife saw these bottles of athlete's foot medicine there. She said, "Charlie, I did not know you had athlete's foot." He said, "I have not, but I thought I might have some day, and that man is passing all these bottles of medicine out, so I took three or four," and that is the situation that the Marshall plan has successfully met, but I am told that if you try to apply the Marshall plan method to this medical business, it will get you involved in so much red tape and so much supervisory staff that it would cost more than it is worth, but I do not know about that.

Senator PEPPER. That is if you are going to apply the means test.

Senator LODGE. No, I do not mean that, but if the man were required to pay every time he got a medical service of any kind, if he had to buy a stamp or do something, I understand that would be impractical.

Senator TAFT. You mean he would not go in and ask for eyeglasses and patent medicines and things the way it is alleged they are doing in England, simply because the services are free?

Senator LODGE. Yes. Let us say that a pair of eyeglasses costs $3 and you oblige your man to pay 25 cents now. That would be a check on the abuse of getting a dozen pair of eyeglasses and selling them to the Indians, or something.

Senator PEPPER. Senator, the only analogy I made about the Marshall plan was I said it does supply the dollar deficit, and I say that some of these other plans that are now before us propose to make up the deficit between what the purchaser can pay and what the purchaser requires. Well, you have a simple plan at least, Senator, as well as a good one. You just give it to the people.

Senator DONNELL. Mr. Chairman, before the Senator leaves, I just want to note I think he has very appropriately indicated at the bottom of his statement the general thought that runs through my mind, at any rate, and that is that each one of these steps is just a precedent for something that goes a little bit further.

He points out in the next to the last paragraph illustrations of what we have already done, workman's compensation, unemployment compensation, and so forth and so on. Then he says:

> Well-conceived health measures should bring measurably nearer the day when the American people will be as physically fit as is humanly possible.

Then he says, and this is what I am driving at:

> This bill is a humble first step toward this inspiring goal.

What I have in mind is if you take this step, the next fellow who comes along with a bill says:

> You took step No. 1, Senator Lodge's step, which is a fine thing. You ought to go a little further and take step No. 2.

Senator Lodge. I reason just the opposite from you. I say there are areas where our competitive system does not reach. The competitive system is a wonderful system, and it is the foundation of our economic welfare and it is the foundation of our political liberty, but like all things, it is not perfect, and if you let unemployment go and do nothing about it, and if you let people have a forlorn old age, and do nothing about it, if you do not do anything to help people with their health, in these fields that the competitive system does not reach, if you do not fill in those chinks, then you are going to endanger the whole competitive system because people are going to lose enthusiasm for it.

I say if you do not undertake sane, well-conceived governmental measures to fill in these chinks, then you are going to run the risk that there will be a loss of enthusiasm for the whole competitive system.

I just reason exactly opposite from you. You think it is going to lead us into something worse. I say if we do not do something like that, we will have something catastrophic take place. It is your judgment as to the future as against mine.

Senator Donnell. Anyway, you agree this is the first step toward this inspired goal.

Senator Lodge. I agree with myself.

Senator Murray. Mr. Cruikshank.

STATEMENT OF NELSON H. CRUIKSHANK, DIRECTOR, SOCIAL INSURANCE ACTIVITIES, AMERICAN FEDERATION OF LABOR—Resumed

Senator Taft. Mr. Cruikshank, you stated one time that there would be no objection to this additional pay-roll tax. In fact, I rather thought that the American Federation of Labor at one time expressed the willingness to pay the whole 3 percent, 4 percent by the employees instead of dividing it between the employees and employers as proposed. Did they not at one time take that position?

Mr. Cruikshank. I do not recall that they did. I would be glad to look it up.

Senator Taft. You say they have no objection, but this social-insurance business of course extends much further than this bill. If we pay the proper cost of old-age pensions, survivors' insurance, we go on to temporary disability, permanent disability, larger pensions, it is going to get up to, as I figure it, somewhere between 15 and 20 percent of pay roll. Do you think this would be an objection when you get to that point?

Mr. CRUIKSHANK. I do not believe, Senator, that it would ever get up that high on any proposals that are now before Congress.

Senator TAFT. Well, what about the railroad retirement pension?

Mr. CRUICKSHANK. It is about 12 now.

Senator TAFT. It is going up to 16 under the pay for the services given under that particular bill, is that not correct?

Mr. CRUICKSHANK. I believe that is right, but I have seen no objection——

Senator TAFT. I am beginning to get quite a few letters from railroad employees wanting to know why this discount is so big, and protesting against the size of it.

Mr. CRUICKSHANK. I know that there has been a widespread inspired campaign by the railroad——

Senator TAFT. The letters I have gotten seem to be rather casual. I have not gotten very many, but they seem to be individuals who themselves felt that way.

Mr. CRUICKSHANK. They do not express themselves on that point at their conventions.

Senator TAFT. No, I imagine it would be rather unpopular in conventions, although we had protests at the time we passed the bill.

Mr. CRUIKSHANK. It would be unpopular in conventions just because most people would support it.

Senator TAFT. You think they would support it, extend it up to 15 or 16 percent?

Mr. CRUIKSHANK. Yes, sir.

Senator TAFT. You think that would not interfere with it. Would you advocate the same approach to housing?

Mr. CRUIKSHANK. No, sir; I would not.

Senator TAFT. Why not? Is not housing very much the same thing? It is inadequate, admittedly inadequate. As you say, medical care is inadequate. What is the difference between housing and medical care?

Mr. CRUIKSHANK. I think that there is an essential difference in housing, in that housing is almost entirely a predictable matter. It is an item that can be budgeted.

Now I agree with you that there needs to be help from Government sources in housing, but a family can plan housing, recreation, its food budget, educational costs.

Senator TAFT. Why cannot it plan medical care if insurance is made available, and I certainly would like to see a condition in which sound medical insurance is available to everybody in the country, and I think it is spreading toward that purpose. What is the difference between budgeting that and budgeting housing, if you want to spread your care, I mean?

Mr. CRUIKSHANK. Yes. The medical costs come largely as an unpredictable item.

Senator TAFT. But they are not an unpredictable item, if you have insurance available and can take out insurance if you want to.

Mr. CRUIKSHANK. If you had insurance plans that would cover all the risks and could avoid the adverse selection, have everybody in it, then you could budget it, which is precisely what we propose to do.

Senator TAFT. What you want to do is to support medical care by Federal subsidy. Now why is it any different to a family earning $3,000 a year whether they pay 20 percent for housing and have their choice of housing, whether they pay 4 percent for medical care and have their choice of medical care? What is the difference?

I cannot understand why one is any different, provided we make available voluntary health insurance throughout the United States so anybody who wants to get it can get it and can budget if he wants to budget.

Mr. CRUIKSHANK. If that were possible.

Senator TAFT. Why is it not possible?

Mr. CRUIKSHANK. It is not possible because in 20 years you only have about 2 percent of the people that have complete medical care——

Senator TAFT. The thing is comparatively recent. It has always been assumed, and maybe wrongly, that people who had nothing could pay for their own medical care. Now in the last 10 years we have had a steady hammering on this business of the catastrophe type of illness, and we have had the biggest growth in hospitalization and medical care, bigger than we have ever seen before, and I cannot see any reason why with proper encouragement we cannot say that voluntary health insurance is available for anybody who wants it. The people who do not want it do not have to take it, and they can get the kind of thing they want.

Mr. CRUIKSHANK. Well, if it were possible to get the controls in the hands of the people so that they could determine what kind of health insurance they have, that might conceivably be possible, but that has not been possible so far. Your so-called voluntary plans—and I say "so-called" because they are not completely voluntary—are set up by and for the doctors and the hospitals.

Senator TAFT. No; I do not think that you are going to reduce the cost. You are saying two things there. The cost is too high. They are not for-profit plans. They fix reasonable salaries. As far as I can see they fix fees that are perfectly in relation with the cost of what you get spread over a large number of people.

Mr. CRUIKSHANK. But they do not cover the risks, Senator.

Senator TAFT. I cannot see the difference, in other words, between such being available and housing. After all, housing is a chance, too. You budget your housing, then you find you cannot stay in that house any more, you are out of that house. You go looking for another one where the rent may be higher. I do not see the difference.

If you take medical service which costs on the average about 4 percent of income, and housing which costs 20 percent of income, I cannot see quite the difference between the Federal Government providing one, giving people something for nothing, not for nothing perhaps, but giving them three times what they pay for in some cases, and giving them in housing three times what they pay for it, provided they are people who can support themselves. I do not know. That is the problem. I do not see quite why if we do have medical care, we should not go on to housing, why we should not go on to food and clothing, as far as that is concerned.

Mr. CRUIKSHANK. Well, I think it is an entirely different thing because of that risk basis. You suggest that we spread the risk through insurance, but you suggest that we spread it through the so-called voluntary plan. Now if we look at these voluntary plans, we find that they do not cover the risk, and that is the difference.

Senator TAFT. Wait a minute, that is a question of cost. Of course, if the Government is going to throw in a lot of general taxation—I would say on the long-range program the voluntary plans cost exactly what the services cost that you get. They do not cover the risks. They do not send people to your home to treat a cold. I do not think they ought to. I do not think the Government ought to; yet, they will have to under national health insurance. They will have to send a doctor anywhere any time anybody asks for a doctor.

Senator PEPPER. Who says so?

Senator TAFT. That is the theory of it. It covers the risk. Mr. Cruikshank says "cover the risk."

Mr. CRUIKSHANK. They pay about a third of the costs now that occur.

Senator TAFT. Oh, no, the Michigan plan pays the cost. If a family takes out that insurance, they get free service for deliveries, for children, all operations, tonsillectomies, every kind of operation, as a matter of fact. What do they not get?

Mr. CRUIKSHANK. There is an income on it. If you want to look at the Michigan plan, we can.

Senator TAFT. What do you mean by "income"?

Mr. CRUIKSHANK. People can have their complete costs covered only if their salary is a certain amount. Usually it is about $2,500 for a married person, and $1,800 for a single person.

Senator TAFT. If they are willing to pay $84——

Mr. CRUIKSHANK. But if their income——

Senator TAFT. $84 a year, $7 a month, they get complete hospital and medical insurance.

Mr. CRUIKSHANK. No. If their income is above a certain point, then the doctor can bill them, and that point is relatively low. The hospital can bill them for extra charges.

Senator TAFT. No. I think you are mistaken about that. Of course if they want a private room, they have got to pay extra. There is no question about that.

Mr. CRUIKSHANK. Here is a summary of the voluntary prepayment medical plan care in all the States, the Territories, and Canada and the District of Columbia. It is issued by the American Medical Association. You look through this.

Senator TAFT. These are on a cost basis?

Mr. CRUIKSHANK. Yes.

Senator TAFT. They charge exactly what it costs? Nobody is making a profit?

Mr. CRUIKSHANK. No, there is no profit. They pay back 90 percent out of the premium dollar.

Senator TAFT. You mean they pay the doctors more than the Government would pay if running a national health insurance program?

Mr. CRUIKSHANK. No. When the person gets his doctor's bill and it is paid by the insurance plan, if his income is above a certain amount, the doctor can bill him in addition so that his insurance has not covered the risk that he is confronted with, and that is true in practically every one of these plans.

Senator TAFT. Well, now is not that only true in the case of industrial plants where they have got the employer as part of the employment agreement?

Mr. CRUIKSHANK. No.

Senator TAFT. When I was there I went around to their offices and it was said if I paid $7 a month, I got full service. Of course, there are certain things they do not give; I agree that they found them so costly that they just figured the service could not give that much, and the Government is going to give a lot of service. I think that is why it is going to be more expensive. I do not know anything about this income question. It is solely on a straight insurance basis.

Mr. CRUIKSHANK. No, that is true of the individual contracts also, and if you look through this bulletin——

Senator MURRAY. What is the name of this publication?

Mr. CRUIKSHANK. Voluntary Prepared Medical Care Plans published in 1948 by the Council on the Medical Services of the American Medical Association.

It describes each plan, the coverages and exclusions and the income limitations, and all of that is laid out in detail, and you find when you study these things just why the coverage and the protection that is described here or that is put out as the solution to all this problem, you find just the reason here that it is not the solution to the problem.

Senator TAFT. Why is it not the solution? My point is whatever the medical care costs, these things are on a cost basis, there is no bureaucratic set-up or anything else that I can discover. If that is on a cost basis, that is just what I believe in. I believe in furnishing the people who can pay for medical insurance on a cost basis. Now if it costs more, that just means the Government service is going to cost more, too, and the taxpayer is going to pay for it, but I cannot understand why the taxpayer should pay for medical service for people who are able to pay for it.

What they can properly pay, I do not know, but roughly we will say they can pay 4 percent of their income. Maybe they can pay 5 percent. Certainly if they can pay 5 percent for movies, they can pay 5 percent for medical care. Whatever that is, if they can pay it, I cannot see why they should not pay it.

Mr. CRUIKSHANK. Well, if the plans that are put forward by the so-called voluntary groups would come forth with a comprehensive plan——

Senator TAFT. But the thing is so experimental, it is so difficult to judge exactly what things cost, what you can give people without it costing too much, that I would think one of the advantages of our plan is that it lets every State try it out. They can try out this plan, they can try out that plan, and in general you are working toward the best possible plan you can get.

Mr. CRUIKSHANK. Well, they have been going at it now for over 20 years. How many people have got to die before we find out their inadequacies.

Senator TAFT. I do not think anybody is dying.

Mr. CRUIKSHANK. People are dying for the lack of medical care, Senator.

Senator TAFT. We still have the best health in the world except about one country, and it has improved about 100 percent in the last 20 years, the same 20 years under our system. Why throw the system away and begin all over again?

Mr. CRUIKSHANK. It is never good enough until it is as good as it can be.

Senator TAFT. That is true of housing and everything else. On that principle you have to give free housing to everybody or tax them 20 percent of their income for free housing. That is a possible plan.

I say that is an extension of Government operation of a Government that is already so overgrown, so hopelessly confused—just read the Hoover reports as to where we are today. Anything to avoid an increase in our Government activity I think is worth trying.

Senator PEPPER. Mr. Cruikshank, are you not going to get quite a lot of Government activity if you have to go around and find out who of these people need some Government help in paying their doctor and drug bills?

Mr. CRUIKSHANK. You certainly are.

Senator TAFT. You have to do that under 1679, too; do you not?

Mr. CRUIKSHANK. No.

Senator TAFT. Mr. Altmeyer's assistant the other day testified they were going to set up a completely additional plan over and above 1679 to take care of all the indigent who could not pay.

Senator PEPPER. We generally talk about 20 percent. I think that is a figure Senator Taft has often used. That applies to only those admittedly indigent who are not gainfully employed. They have already gone through the test.

They have been through the test generally. That does not mean that you go around to the man making $2,500, the man making $2,550, $2,600, $2,800, $3,200, $3,480, and all those different classes and finally find out whether that man and his family can pay for the medical services that they require.

Now if that has got to be done in every individual case, unless you do as somebody suggested, say, "All right, everybody making less than $2,500 is covered," if they want to put that in the plans, at least we will know where we are.

Senator TAFT. Every city in the United States does it today.

Senator PEPPER. If you are going to start out with what this bill promises. as I read here a minute ago, contemplates rather, that within 5 years they will make up the deficit between the cost of the medical services the people of this country have, and what they are able to pay, how can you avoid a necessary examination of every man and every woman's ability to pay through some sort of a public employee?

Mr. CRUIKSHANK. You cannot avoid it at all, and if Senator Taft can say that the means test is just a bogie, but I am sure he would find difficulty in finding a public-welfare person in that field who would say that the means test was just a bogie. They do not like it any more than the people who are submitted to it.

Senator TAFT. Every public-housing authority is conducting it today without the slightest difficulty.

Mr. CRUIKSHANK. I submit. Senator, that is a completely different thing. That is an income status.

Senator TAFT. Why is it if a man has over a certain income he cannot get in, so they need to find out what his income is. That is exactly the same as this.

Senator PEPPER. Oh, no; that is the indigent people, Senator. That is the lower-than-20 percent.

Senator TAFT. Oh, no, no.

Senator PEPPER. What percentage of the people are eligible?

Senator TAFT. These housing people are not indigent. They get in if they have less than a certain income, which is figured out on a mathematical basis, and you have to find out what their income is, you have to question them, you have to submit them to that means test.

Mr. CRUIKSHANK. It is a quite different thing because you do not have to go into the whole matter of what their other assets are.

Senator TAFT. You certainly do. All of those things are income. I will make this "income" if you want it that way. That point has never been raised before, so it had not occurred to me, but you have got income as the whole basis of the means test.

Mr. CRUIKSHANK. Income is not the whole basis at all. If you have ever seen a means test in operation you know that it is only a small part of it.

Senator TAFT. We will cut that out, we will change the bill to cut that out. That is not a basic question at all. Nobody is concerned about that.

Mr. CRUIKSHANK. After you have cut out any possibility of their being a means test, then we will be glad to look at your bill again.

Senator TAFT. That is not a means test. The question is whether they have the income sufficient to pay, and that is exactly the question you have in housing, exactly the question you have in many other features.

Incidentally, it is the question everyone has on the income tax to determine how much taxes he pays. That is all a means test is in this bill. We do not say means test. There is no technical definition of it, I agree. We will make it more technical, if you want to.

Senator PEPPER. You were in the room a minute ago when we were discussing this matter that Senator Lodge presented. Now if we take this objective that is declared over here, that within 5 years these State plans are supposed to devise procedures by which everybody is able to have public assistance, with the public supplying the deficit between what they could pay and what adequate medical care would cost, to get the needed medical services for the country, if you start out with that assumption, is it or is it not a fact that in your opinion it will require giving some assistance to a great majority of the population of the country?

Mr. CRUIKSHANK. Very definitely it is. I think it would be. I think all families today would be included, $5,000 a year or under.

Senator PEPPER. And that is far above the median level of the income of the families of the country.

Mr. CRUIKSHANK. That is right, sir.

Senator PEPPER. Well, do you agree with me that if you are going to do what these bills seem to contemplate of making up the deficit for the American people in making it possible for them to get the medical services that they require, it is going to make a heavy drain upon the Public Treasury of certainly 1, 2, or 3 billion dollars a year?

Mr. CRUIKSHANK. It will make a very heavy drain, and there will not be the compensating restraint on the part of the people with the sense that they are paying for it. It will be just a hand-out of the

Federal Treasury without the sense of participation they have in a contributory system.

Senator PEPPER. And it will not have restraints. As Senator Taft said a minute ago, some of the railroad people are beginning to say, "You are beginning to take too much out of my wages." Now if we had the national health insurance plan in effect and somebody contemplated that it be vastly expanded, why would not all these taxpayers and wage earners know that that meant an increase in the payroll tax or in the income contribution that they had to make to the system.

Mr. CRUIKSHANK. That is right.

Senator PEPPER. And therefore there is that restraint.

Now the next thing is none of these other plans levy or contemplate the levy of any tax to meet these costs or drains upon the Public Treasury, do they?

Mr. CRUIKSHANK. Not to my knowledge.

Senator PEPPER. The only direct drain upon the Public Treasury in the national health insurance bill is, is it not, the possible 1 percent of pay roll which might come out of general taxation?

Mr. CRUIKSHANK. That is right.

Senator PEPPER. Not to exceed 1 percent, but 3 percent, three-fourths of the bill in theory and contemplation carries its own revenue, provides its own sources of income, and therefore does not constitute the threat to the unbalancing of the budget that the other plans contemplate. Now one other thing, Mr. Cruikshank——

Senator TAFT. Wait a moment. This plan contemplates getting out $1,400,000,000 out of general taxes, whereas ours contemplates $300,000,000.

Senator PEPPER. It is a peculiar thing to me that the able Senator in one breath says he is going to give everybody the health care that they cannot pay for, and when we propose to do that, it is going to cost $5,000,000,000 or $6,000,000,000, but when he proposes to do it, it is going to cost only $300,000,000.

Senator TAFT. Let me ask this: The city of Cincinnati today is spending $2,000,000 for the maintenance of a general hospital for the treatment of people who cannot pay. Is the Federal Government going to relieve them under 1679? Yes, it is. That is just why it is so expensive. You are taking over all the costs of all the State and city governments who are now providing medical care free to 80 percent of the people.

Senator PEPPER. They are not doing any such thing, if I may say so. What is given by way of charity, what is given to the indigent is a separate matter from the national health insurance bill.

That is something that we propose to deal with in separate legislation or in separate title. It will be dealt with just as it is now, just as you propose to deal with it by Federal grants, Federal and State funds that are provided.

Senator TAFT. And a means test?

Senator PEPPER. Yes, that is a means test, of course it is, but we are talking only about the indigent, the one that is not gainfully employed. Now the Senator if he will tell us—let the country know that he has a bill to take care of the indigents of this country, then that is all right. We are doing that now and everybody wants to do that, take care of the unemployed indigents.

If that is what he is proposing to do, as he started off saying he was in the beginning, to take care of the 20 percent who cannot take care of themselves, then we know what we are talking about, but we are talking, in the national health insurance bill, about a plan by which the white-collar worker, everybody that is gainfully employed, by contributing a part of his income or wages, can buy his health care without becoming a charity patient subject to a means test.

Now when the Senator gets into that class the gainfully employed who is not one of the current indigents, then I cannot see that he has offered anything that is adequate to them except he holds out here in one aspect of the matter, that out of the Public Treasury, Federal and State, we are going to take every man and every woman and every child's doctor and hospital and medical and nurse bill, to the extent he cannot pay for it, we are going to give him the money to pay for it. Now if the American people thoroughly understand that is what he is proposing, then we have got something we can debate.

Senator TAFT. I suppose two-thirds of the people in that general hospital, or more, are gainfully employed at regular salaries, and yet the city of Cincinnati is taking care of them because they are what we call medically indigent. They are not able to pay at the moment, or it is too heavy a burden for them at the time, and as far as I can see the bill is going to take that burden off the city's shoulders.

Senator PEPPER. We are not doing that.

Senator TAFT. That is the reason why our plan does not cost more than $300,000,000, because the States and local governments are paying probably close to $2,000,000,000 of their own money.

Senator PEPPER. If the Senator will take the hospital to which he referred and see how much it is costing the Cincinnati hospital to give the services it is now giving, and find out how much that is for the average person, and multiply that by the number of people in the country, then maybe we can get some idea of what his plan would cost the Public Treasury, because that is what he proposes for everybody.

Senator TAFT. No, no, I only intend to give the money to the States to enable them to do this job more completely and fill out the gaps that they are not now filling.

Senator PEPPER. Do just what the Cincinnati hospital is doing.

Senator TAFT. Yes, but more completely. I agree there are many places where it is not done adequately, and we contend that $300,000,000 added to what the States and localities are doing, will do that job. That is the basis for why the cost is so different from the Federal Government stepping in and paying the cost of everything.

Mr. CRUIKSHANK. I think a very important thing is, in Cincinnati, that program does not do anything at all about keeping people out of the hospital. There is no provision for any preventive service in that program or in the program envisioned in that bill. People who have operated these other programs——

Senator TAFT. We have a lot of free clinics in connection with general hospitals and other hospitals. There are plenty of free clinics where people can go and get that preliminary care, to say nothing of the fact that I am strong for extending the public health units and the various things which can serve to prevent these things. I agree the preventive field is one that is peculiarly for Government and I am all for it.

Mr. CRUIKSHANK. But the people cannot get the preventive service and the periodic examinations. Go through this list again and you will see that in every one of these that I checked through just within the last 48 hours, the periodic examinations, the preventive services specifically excluded, and that has a serious adverse effect on the quality of medical care that is rendered to people.

Senator PEPPER. Mr. Cruikshank, you are representing here, as you testified, not yourself only but the American Federation of Labor which has a membership of how many people?

Mr. CRUIKSHANK. Just short of 8,000,000 people.

Senator PEPPER. They with their families constitute a considerable segment of the population of this country, do they not?

Mr. CRUIKSHANK. Nearly 25,000,000.

Senator PEPPER. You have been in this field a long time, and I regard you as one of the most qualified men, the best qualified man in this field. I would like to ask you this question.

There are 197,000, I believe it is, doctors in the country, most of them fine, honorable, able men and women. Now do you feel that 197,000 doctors who administer medical care to people of the country have a right to deny to the working people—for example, the people generally or to their public representatives—the right to devise a system, even if it includes compulsory taxes levied upon them, compulsory insurance, by which they can pay for the medical care that they require?

Do you regard the medical profession as having the right to deny to the consuming public their services, the right to devise the best plan to provide funds by which their services can be paid for that can be devised?

Mr. CRUIKSHANK. I do not believe they have that right, and I do not believe that the great bulk of the doctors in the United States would even want to have that right.

Senator PEPPER. Is that not just exactly what the national health insurance bill is? It is simply a method by which the people are trying to get themselves in position to pay the doctor's bills and the hospital bills and the nurse's bills and the medical bills.

Mr. CRUIKSHANK. As I understand it, that is exactly what it is.

Senator PEPPER. And in no sense of the word is it intended to, or designed to, interfere with the professional functions of those who are technicians, the doctors, nurses, and all the others in the field of administering medical care.

Mr. CRUIKSHANK. That is the way we understand it, yes, sir.

Senator TAFT. Can you tell me the total pay-roll tax that would be required by all of the insurance plans that have been approved and advocated by the American Federation of Labor added together?

Mr. CRUIKSHANK. I can give you some estimate, I think. I have a note on it here somewhere. The increased old-age and survivors insurance program over a period of years would run probably about 7 percent of pay roll.

Senator TAFT. Employer and employee together?

Mr. CRUIKSHANK. Yes, about 7 percent of pay roll.

Senator TAFT. I thought that this plan alone was equal to 4 percent of all pay-roll taxes——

Mr. CRUIKSHANK. I am talking just about the old-age and survivors' insurance program over a period of years which would run about 7 percent. The disability program would run about 1 percent. We estimate that this program would probably cost about 3½. That would run about 11½ percent of pay roll, and unemployment compensation would run on a long-term basis about 2 percent of pay roll.

Senator TAFT. What about workmen's compensation? Is that covered?

Mr. CRUIKSHANK. No. Workmen's compensation, as you know, is a completely separate program and is completely employer-financed.

Senator TAFT. It is not universal, is it?

Mr. CRUIKSHANK. Yes, it is.

Senator TAFT. Thank you, very much.

Senator MURRAY. This problem of budgeting for the various needs of life is not a very simple matter for people that have an income of only about $5,000 a year, for example.

Now I can see how they could budget for housing and for food and for things like that, but when it comes to budgeting for health care, it is a little different because the average person starts out in life healthy and does not have the need for a doctor.

For instance, Senator Taft, I think, never had a doctor in his life. He is a healthy man and he has always been able to get along without having to spend any money on medical care, so that the average young family will not undertake to budget for health care because they have so many other drains on them.

They have their children to educate and to dress, and they have to provide some budgeting for rest and recreation and for some social life, theaters, and so forth. That is an absolute essential to the average American, is it not?

Mr. CRUIKSHANK. That is quite right.

Senator MURRAY. So when they get down to the point of budgeting for something that is not right before them at the moment, they are not going to budget for it.

Mr. CRUIKSHANK. Those other items that he mentioned are not comparable at all because they are predictable items. The cost of medical care is an unpredictable item as to time and severity.

A workingman does not face even the possibility of being forced to live in a $50,000 mansion, but he does face the possibility of having to have the same kind of an operation or service that the man who lives in a $50,000 mansion may have to have, so that they are not comparable items at all.

I have noted in an article in Collier's magazine that was published last summer, written by Governor Warren of California, and he advocated this same type of program for his State. He gave an example of a man earning $40 a week, having a wife and two children. He had a $1,345 bill incurred by this wife through a major operation for what the Governor in his article called a common stomach disorder.

Well, now when we apply the way that man would have to face that contingency through the different proposed programs, we get a picture of the way it would operate. Under national health insurance as proposed in your bill, he would pay $31.20 to protect himself and his wife and his children. There is no single plan or combination of Blue Cross, Blue Shield plans that would give him comparable protection at that cost.

In your own State, Senator, the Blue Cross, Blue Shield protection for this family would come to $84.50 a year, but it would not cover the costs of care by his own family physician, the services of a specialist at the office, immunization, prenatal care, eyeglasses, appliances, dental care, or home nursing services.

In other words, the voluntary protection available to him in that State would cost him twice as much as the national health insurance protection, and offer him about half as much protection as he would get, and that is fairly typical through the country.

Before it slips my mind, Senator, I had intended to introduce these charts so that you and your colleagues could look at these comparable costs and comparable coverages of the health insurance plan and the United Medical Service and the health insurance plan and the Group Health Executive Service in New York City, which I would like to submit for the record, if I may.

Senator MURRAY. They may be incorporated in the record.

(The documents above referred to are as follows:)

Major benefits[1] *provided by health insurance plan and by United Medical Service "surgical" plan*

Features	United Medical Service	Health insurance plan
Home calls	Not provided	Unlimited.
Office calls	do	Do.
Hospital calls	Limited to the number days of care after operation or delivery specified in contract.[2]	Do.
Surgical care	Provided[3] in accordance with fee schedule. $225 maximum indemnity.[2]	Do.
Preventive care (regular health check-ups, etc.)	Not provided	Provided.
Maternity care (before and after birth)	Family contracts only.[3] $75 maximum indemnity for all care plus delivery.[2]	Do.
Child care (in family contracts)	Not provided for first 90 days and only as hospitalized surgical case thereafter.	Do.
Chemical and biological tests and procedures in laboratory.	Not provided	Do.
Eye tests, prescriptions for eyeglasses, etc	do	Do.
Heat treatments, massage, exercises, ultraviolet and radio therapy.	do	Do.
X-ray examinations and treatments	do	Do.
Immunizations for diphtheria, smallpox, whooping cough, measles, etc.	do	Do.
Administering of blood and plasma	do	Do.
Specialist care for ear, nose, and throat conditions	do	Do.
Specialist care for kidney and bladder conditions	do	Do.
Specialist care for skin diseases	do	Do.
Specialist care for bone and joint conditions	do	Do.
Advice for mental and nervous conditions	do	Do.
Visiting nurse service	do	Do.
Treatment of allergies such as hay fever, skin conditions, asthma, etc.	do	Do.

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[1] This chart is a summary of some of the features. A detailed comparison can be submitted with respect to every phase of the contracts referred to above.

[2] If income exceeds $2,500 ($1,800 individual) subscriber pays difference between rate allowed and total doctor's bill.

[3] Waiting period of 11 months for preexisting conditions and 10 months for delivery waived for groups of 50 or more.

THE ADVANTAGES OF HEALTH INSURANCE PLAN

Comprehensive care—at patient's home, doctors' offices, or hospital.

Preventive care—regular health examinations, immunizations, etc.

Finest care through groups of approved physicians practising teamwork medicine.

No age limits, no waiting periods, no physical examination required to join.
No doctors' bills to worry about.
The best plan for medical care.

	Monthly rate	
	United Medical Service	Health insurance plan
1 person	$0.40	$2.42
2 persons	1.00	4.84
3 or more persons	1.80	7.25

Major benefits[1] *provided by health insurance plan and by Group Health Executive-all-Illness plan*

Features	Group health insurance	Health insurance plan
Home calls	$4 per visit.[2] Maximum of 100 visits per illness and 1 visit per day.	Unlimited.
Office calls	$3 per visit.[2] Maximum of 100 visits per illness and 1 visit per day.	Do.
Hospital calls	Maximum of $100 for 10 day stay and of $908 for 201 days medical nonsurgical care.[2]	Do.
Surgical care	Quarantineable diseases excluded. Provided up to double the specified base rates. $450[2] maximum indemnity[3] for any one operation.[4]	Do.
Preventive care (regular health check-ups, etc.)	$3 for visit to doctor's office[2]	Provided.
Maternity care (before and after birth)	$140 maximum allowance for delivery and postnatal care.[2][4] No prenatal care.	Do.
Child care (in family contracts)	Not provided for first 90 days of child's life.	Do.
Chemical and biological tests and procedures in laboratory.	Not provided unless performed in doctor's laboratory, $3 a visit limit.[2]	Do.
Eye tests, prescriptions for eyeglasses, etc	Not provided	Do.
Heat treatments, massage, exercises, ultraviolet and radio therapy.	Radio therapy for malignant conditions only. $3 for visit to doctor's office.[2]	Do.
X-ray examinations and treatments	Application of deep X-ray at $10 per treatment. $200 maximum X-ray examinations, $3 per visit limit.[2]	Do.
Immunizations for diphtheria, smallpox, whooping cough, measles, etc.	$3 for visit to doctor's office	Do.
Administering of blood and plasma	Not provided	Do.
Specialist care for ear, nose, and throat conditions	Home visit, $4; office visit, $3. One hospital consultation at $20.	Do.
Specialist care for kidney and bladder conditions	do	Do.
Specialist care for skin diseases	do	Do.
Specialist care for bone and joint conditions	do	Do.
Advice for mental and nervous conditions	Provided	Do.
Visiting nurse service	Not provided except in surgical obstetrical or hospitalized cases.	Do.
Treatment of allergies such as hay fever, skin conditions, asthma, etc.	Home visit, $4; office visit, $3. One hospital consultation.	Do.

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[1] This chart is a summary of some of the features. A detailed comparison can be submitted with respect to every phase of the contracts referred to above.

[2] Specified indemnity need not pay entire bill.

[3] Indemnity will not be paid for more than any one type of care (surgical, obstetrical, or medical) during any one period of hospitalization.

[4] Waiting period of 11 months for preexisting conditions and 10 months for delivery waived for groups of 50 or more.

THE ADVANTAGES OF HEALTH INSURANCE PLAN

Comprehensive care—at patient's home, doctors' offices, or hospital.
Preventive care—regular health examinations, immunizations, etc.
Finest care through groups of approved physicians practicising teamwork medicine.

No age limits, no waiting periods, no physical examination required to join.
No doctors' bills to worry about.
The best plan for medical care.

	Family monthly rates	
	Group health insurance	Health insurance plan
1 person	$2.70	$2.42
2 persons	5.95	4.84
3 or more persons	6.75	7.25

Senator MURRAY. Now, Mr. Cruikshank, you have visited England, have you not, where a health program is now under operation there?

Mr. CRUIKSHANK. When I was last in England it was before the time of the new program. I was there at a time when they had the rather limited health insurance plan in operation. I have not been there since the inception of the new plan.

Senator MURRAY. Therefore you have no information for us on that?

Mr. CRUIKSHANK. Well, I am in correspondence with our trade-union people in England. I have had rather extensive correspondence with some of them because we have been conscious of the criticisms that have been launched in this country about that plan, and I have asked them, as they represent the people who are covered by it, if these criticisms are well founded, and I have in my files replies from these people telling us how the program is working from the point of view of the people for whom the protection is designed, and they are quite caustic, some of them, in their comments about the type of criticism that has been launched against their plan.

Senator MURRAY. As I understand it, this medical care program over there has come to be recognized as one of the most popular programs the labor government has introduced.

Mr. CRUIKSHANK. It is so recognized to the extent that when Churchill recently stated in the House, made some criticisms of it, there were immediate caucuses of the Tory Party and they came out within 48 hours with the statement that when and if they were returned to power, that whatever they did they would not do away with the medical-service plan.

Senator MURRAY. And is it not a fact that some of them have been claiming that it was the Tories that originally proposed the program?

Mr. CRUIKSHANK. That is right.

Senator MURRAY. And they want to have the credit for having presented that very valuable system to the English people. Is that true?

Mr. CRUIKSHANK. I think that is correct, sir.

Senator MURRAY. You have another pamphlet there or publication that you referred to a few times. Have you described that so we may get a copy of it?

Mr. CRUIKSHANK. I could give you this copy, Senator.

Senator MURRAY. We will be very glad to have that.

Senator MURRAY. Now Senator Donnell.

Senator DONNELL. I have just a few questions, Mr. Chairman. How long has it been since you were in England?

Mr. CRUIKSHANK. I was in England in the winter of 1946.

Senator DONNELL. Did you have occasion to look into the question as to whether or not there were some certain volumes of regulations that were then in force under the English system?

Mr. CRUIKSHANK. No. The new system had not gone into effect.

Senator DONNELL. I didn't mean the new system. I mean the old system.

Mr. CRUIKSHANK. No. I talked with Mr. Smythe, the chief administrator of the program at that time. I was only in England a short time, and I did not have occasion to make any extensive study of the operation of the program.

Senator DONNELL. How long were you in England at that time?

Mr. CRUIKSHANK. About 10 days.

Senator DONNELL. About 10 days.

Senator MURRAY. That was 2 days longer than Dr. Fishbein was there, was it not?

Mr. CRUIKSHANK. It was 4 days longer.

Senator DONNELL. You say you did not make any extensive investigation. You did not see the volumes of regulations that were then in force in England under the old plan, is that right?

Mr. CRUIKSHANK. No, sir.

Senator DONNELL. I am correct in that, am I?

Mr. CRUIKSHANK. Yes, sir.

Senator MURRAY. Senator, do those volumes apply to the entire social security system of England, or just merely to the medical care?

Senator DONNELL. I was under the impression that they applied to the medical care. I am talking about the ones that we have had placed in evidence here before.

Senator MURRAY. My understanding is that they comprise the entire social security system of the British.

Mr. CRUIKSHANK. I did see an item recently in the Lancet, their professional journal. I had only been familiar with it by reference to Sherlock Holmes stories before. The Lancet editorial stated that the doctors themselves were getting along very well under this system and they did not find it burdensome. I take it that that is the opinion of the profession of England, or was at that time.

Senator DONNELL. What I am talking about, Senator Murray, are the books that are here in evidence, large, thick books, 2 or 3 inches thick, and they weighed several pounds.

Senator MURRAY. I recall them.

Senator DONNELL. That is what I shall certainly check into, and we will see just what they do relate to.

Now, Mr. Cruikshank, you were talking about the means test and you say in your statement at the top of page 3:

> In order to be eligible for benefits under this bill—

you are speaking of 1581—

> a person would first have to be certified as needy after investigation of his finances. This is repugnant to the American working people and will never be accepted by them as a substitute for health insurance.

Why do you think "this is repugnant to the American working people," to be certified as needy after investigation of finances?

Mr. Cruikshank. Well, sir, the experience is that many of our people have gone through over a period of years, and particularly during the time of the depression, particularly in the early days when aid was made available through the cities and the States and the Federal Emergency Relief Administration purely on the basis of proven need, very humiliating experiences.

I happened in 1931 to be in charge of the relief program for the Brooklyn Federation of Churches. We had 580 parishes in Brooklyn, and these people were coming into my office establishing their need for the pitiful little pittances that were made available through the city of New York at that time, and I myself never had such uncomfortable experiences as I had in being in charge of that program and seeing people who, for all their years, had been able to support themselves, to pay their bills and to provide for their families, coming in and submitting to the kind of thing which under the regulations we were required to submit them to.

We had to find out how long they would be unemployed, how much of an equity they had in their home, whether they owned an automobile, whether it was owned free and clear or whether they had some payments due on it, what need they had of keeping a car, whether they owned a radio, whether they had an equity in life insurance, and all of those personal and private affairs.

I have seen people go down to the level of abject starvation in the midst of the richest city in America before being willing to submit themselves to that humiliating process, and I know from my contacts over many years with working people that that is the most repugnant thing to them, and they will accept almost any other kind of method of providing for their needs rather than that.

Senator Donnell. You have studied S. 1679, have you, Mr. Cruikshank?

Mr. Cruikshank. I have read it over and tried to give it a thorough study.

Senator Donnell. Does it contemplate trying to take care of the indigents, the needy?

Mr. Cruikshank. Yes, it recognizes that in the insurance program there will always be those who for one reason or another are not caught up in the insurance program, and therefore has a provision for taking care of those who have been certified as in case of need.

Senator Donnell. So in the case of that particular segment, then, to which you now refer, there would be a means test imposed even under 1679, is that right?

Mr. Cruikshank. Yes, sir. It is those that are left over that are not caught up in the other program.

Senator Donnell. Very well. The section to which you are referring is section 705:

> Any or all benefits provided under this title to individuals eligible for such benefits may be furnished to individuals (including the needy) not otherwise eligible therefor for any period for which equitable reimbursements to the account on behalf of such needy or other individuals have been made.

Is that the section to which you refer?

Mr. Cruikshank. I believe so; yes.

Senator Donnell. Mr. Cruikshank, at the outset of your testimony you quoted from a resolution of the American Federation of Labor or executive council, August 1948, in which occurs this clause, about the middle of the first paragraph:

> We have no desire to socialize the practice of medicine.

What is the meaning of the word "socialize" as applied to the practice of medicine in that particular clause as you understand it?

Mr. CRUIKSHANK. Well, I am quite certain that the clause itself was included in the report of the executive council in a partial reply to those who have claimed that the social insurance approach was an attempt to socialize the practice of medicine.

Senator DONNELL. By saying "We have no desire to socialize the practice of medicine," just what was it that the American Federation of Labor was expressing itself as having no desire to do?

Mr. CRUIKSHANK. In my conversations with the members of the executive council when we have discussed this, and with the members of our social security committee, their idea of socializing medicine—I am just trying now to gather together many concepts and expressions and conversations without attempting to quote any individual or specific instance—they would think of socializing the practice of medicine by the Government taking over all its operations and owning and operating the hospitals and health centers and putting all the doctors on the Federal pay roll, a kind of State medicine concept.

Senator DONNELL. Well, now, under S. 1679 you will recall that section 700, in declaring the policy under title VII, which is the prepaid personal health insurance benefits section title, says this, does it not:

> The Congress hereby declares that it is the policy of the United States to take such steps and to utilize such of its resources as are necessary toward making adequate health services available to all our people regardless of residence, race, creed, color, or economic status.

Do you recall that language?

Mr. CRUIKSHANK. Yes, sir.

Senator DONNELL. So it is the resources, then, of the United States which the Congress is going to utilize in making these adequate health services available. Do you understand that to be the purpose of this bill, S. 1679?

Mr. CRUIKSHANK. That is right, that is the specifically stated purpose. I think that needs to be related to the over-all statement of purpose in the preamble to the bill.

Senator DONNELL. All right, now what particular part of that over-all statement do you wish to call attention to?

Mr. CRUIKSHANK. I would have to look at it a minute, if I may, Senator. Well, take section 3 at the top of page 9:

> In establishing a system of national health insurance, it is the policy of this act that those persons and their dependents who are insured under the provisions of the act shall pay for its benefits in proportion to their incomes, and shall, therefore, receive its benefits as a right and not as charity—

And these freedoms and guaranties are listed.

Now that is the statement of principle relating to the insurance approach which modifies a bald statement that all the resources of the Government are going to be directed to the purpose.

Senator DONNELL. All right, read two together, but the fact remains, does it not, that in setting forth title VII:

> The Congress does declare that it is the policy of the United States to take such steps and to utilize such of its resources—

that is the resources of the United States—

as are necessary toward making this health service available.

That is correct, is it not?

Mr. CRUIKSHANK. Well, through the system that is set up.

Senator DONNELL. Through the system that is set up. The point I am making is that it is governmental resources that are to be used, some of which are to be derived by taxation. The method of taxation does not appear, by the way, does it, in this bill?

Mr. CRUIKSHANK. No, sir.

Senator DONNELL. You talk about a 3-percent pay roll tax. Is there anything in this bill that says there is going to be a 3-percent pay-roll tax?

Mr. CRUIKSHANK. No. There is an authorization for appropriation of funds to that amount.

Senator DONNELL. But this bill does not say anything about how the money is going to be raised, does it?

Mr. CRUIKSHANK. No, sir.

Senator DONNELL. Do you know why that was left out of the bill? I notice you refer to this bill as our bill at one point. Do you know how this provision as to how this money is to be raised happened to be left out of this bill?

Mr. CRUIKSHANK. I do not know precisely, but we would understand that the revenue matters of any of these bills are appropriately the concern of other committees; that the substantive proposals are appropriately the concern of this committee.

Senator MURRAY. The same situation occurs in all the bills. Senator Donnell's own bill does not have a different method.

Senator DONNELL. I am talking about this bill for the moment right here. You speak of this as being your bill. By the way, what do you mean by that? Have you cooperated and collaborated in the preparation of it?

Mr. CRUIKSHANK. I have not sat with those who actually drafted the bill. I referred in my testimony to specifications that the social security committee was required to draw up regarding a health insurance program.

These specifications were drawn up in January. They were approved by the executive council in February, the February meeting, following which, upon their approval, President Green sent them to the President and also sent a copy to the Surgeon General, and he sent copies to the chairmen of the appropriate committees of both the House and the Senate.

Senator MURRAY. And he has several times testified.

Mr. CRUIKSHANK. Yes; in that relation. This bill does meet the specifications which we drew up as the specifications which would have to be in a bill which would receive our endorsement.

Senator DONNELL. Very well, and this bill contemplates that the Government is taking over functions here which the Government does not now have, and that included in those functions is the raising of moneys with which to finance it, some portion of which you understand is to be from pay-roll taxes and some portion of it is to be out of the general revenues if such latter portion is necessary to pay the differences between the cost and the amount derived from pay-roll taxes. That is right, is it not?

Mr. Cruikshank. That is right. Of course, the residue is designated in this bill as 1 percent.

Senator Murray. Senator, I would just like to interrupt you. They have sent the Sergeant at Arms to get you. He says you have to go back and register again. We will recess for a few minutes.

(Short recess.)

Senator Murray. Proceed.

Senator Donnell. Mr. Cruikshank, I was addressing myself to line of questioning which arose out of your comment here that the American Federation of Labor—and I am quoting from the excutive council—has "no desire to socialize the practice of medicine."

Now I just want to analyze somewhat briefly with you just what this bill does, and I just pointed out by my questions, to which you have assented, the statement which you made about combining the allegations in the preamble and the part that I quoted to you, you have agreed, I take it, that Congress is going to raise money, governmental funds, part of which are derived from pay-roll taxes and part of which are derived from general revenue if the latter be needed, in order to carry out this plan of providing prepaid personal health insurance benefits. That is correct, is it not?

Mr. Cruikshank. Yes; with the limitations specified.

Senator Donnell. But you say they are going to raise governmental funds.

Mr. Cruikshank. That is right.

Senator Donnell. Then there is a provision in this bill, is there not, by which the operations of the bill are to be carried out under the supervision of one top Federal governmental official. That is correct, is it not?

Mr. Cruikshank. Yes, sir.

Senator Donnell. And that top governmental official is the Federal Security Administrator. That is correct, is it not?

Mr. Cruikshank. Well, of course, the bill also provides for a great deal of local participation.

Senator Donnell. What does it first provide? I would like to get your answer on one question at a time.

Mr. Cruikshank. He has limited authority; yes, sir.

Senator Donnell. He has limited authorities?

Mr. Cruikshank. Yes, sir.

Senator Donnell. What are the limits of it, if you know?

Mr. Cruikshank. Well, the bill provides for a maximum of local participation on the part of the consumers and on the part of the doctors. In fact, that is stated in the purpose of the bill at the outset.

Senator Donnell. You are familiar with the fact, are you not, Mr. Cruikshank, at the bottom of page 129, that the bill says:

> In exercising their functions and discharging their responsibilities under this title local administrative officers and communities, local advisory committees, and local professional committees shall observe the provisions of this title, and regulations prescribed thereunder, and of any regulations, standards, and procedures prescribed by the State agency.

You are familiar with that, are you not?

Mr. Cruikshank. Yes, sir.

Senator Donnell. Now, the regulations that are prescribed under this title are regulations that are referred to at page 138, at least in part, of the bill, are they not?

Mr. CRUIKSHANK. I do not recall the exact page.

Senator DONNELL. Do you have a copy of the bill before you?

Mr. CRUIKSHANK. Yes, sir.

Senator DONNELL. The bill says:

> The Board—

that is, the National Health Insurance Board—

> shall perform such functions as it finds necessary to carry out the provisions of this title, and shall make all regulations and standards specifically authorized to be made in this title and such other regulations not inconsistent with this title as may be necessary.

That is the language, is it not?

Mr. CRUIKSHANK. That is right.

Senator DONNELL. Now, you spoke about the limited authority of the Federal Security Administrator. I call your attention, Mr. Cruikshank, to the immediately preceding sentence at the bottom of page 137 and the top of 138, which reads:

> All functions of the Board shall be administered by the Board under the direction and supervision of the Federal Security Administrator.

You observe that, do you not?

Mr. CRUIKSHANK. Yes, sir.

Senator DONNELL. So that then we have here some type of plan of prepaid health insurance benefits which are described here in this bill in great detail, which are to be financed by moneys raised in the two ways that you have indicated, and are to be under the supervision of a governmental board, which latter board is in itself subject to the direction of one Federal Security Administrator. That is correct, is it not?

Mr. CRUIKSHANK. Well, there is also an advisory council and also the Board has the duty to study, make recommendations, and report to Congress. The Board reports directly to Congress. Now there is a check on that Administrator that is a very real check as we observe governmental organizations in operation.

Senator DONNELL. But the language is:

> All functions of the Board shall be administered by the Board under the direction and supervision of a Federal Security Administrator.

Mr. CRUIKSHANK. Yes; that language is as stated, but that does not completely or adequately describe the operation of the program because it has to be taken in its context with the other provisions of the bill which provide checks.

Senator DONNELL. I cannot see any possible check that you find in this bill with respect to the administration by the Board of its functions. It is prescribed as clearly as the English language can prescribe it:

> The functions shall be administered under the direction and supervision of the Social Security Administrator.

Mr. CRUIKSHANK. Let us take an example and say the Federal Security Administrator some day should be an irresponsible person and unresponsive to the wishes of the people. His Board would immediately be taking issue with him.

What would happen to a Federal Security Adiministrator whose Board was reporting to Congress all his misdeeds and failures in office? That is a constant and running check on the Administrator.

Senator DONNELL. Well, Mr. Cruikshank, there may be a check or there may not be a check. The fact is that these functions are to be administered as I have read, under his direction, and when you have the power of direction that is the power of control of the action of the Board, is it not?

Mr. CRUIKSHANK. Within those limitations.

Senator DONNELL. There are no limitations as far as I can see except, of course, if Congress finds out this plan does not work well, it could always repeal the plan. That is true, is it not?

Mr. CRUIKSHANK. That is right, and it could change and modify the plan and the Administrator would not have any more funds to deal with than were appropriated each year.

Senator DONNELL. Certainly that is true, but as long as the appropriations are made and as long as this act which you are asking us to pass shall be in effect, it is to be carried out under this language that I have read, namely that "all functions of the Board shall be administered by the Board under the direction and supervision of the Federal Security Administrator." That is right, is it not?

Mr. CRUIKSHANK. That is right.

Senator MURRAY. Senator, might I inquire there is it not a fact that that language with reference to the authority of the Federal Security Administrator applies merely to requiring that the actions of the Board or the operations of the Board shall be within the language of the statute, within the law? I do not understand from this language that he is going to direct the Board as to what to do or supervise what they do except to the extent that it must be in compliance with the law.

Senator DONNELL. That is not what it says, Senator:

> All functions of the Board shall be administered by the Board under the direction and supervision of the Federal Security Administrator.

Senator MURRAY. We have had that every time we have had a hearing, and it has been discussed back and forth by the hour. I guess there are no doubt several hundred pages of the record here during the last several years which have reference to that, and my understanding is that that does not give the Administrator any such authority as you would infer.

It does not do anything more than to merely require that the administration of the act shall be under the direction of some single person who will see that it is carried out within the spirit of the law, and it seems to me that under this the Board is entirely free, that it makes its reports to the Congress, and I cannot see how you can contend that the Federal Security Administrator is going to assume the jurisdiction of telling the Board what to do and how this act should be carried into effect.

Senator DONNELL. I can only reiterate the fact that the bill says what I have said, and I think it is perfectly clear.

Mr. CRUIKSHANK. I think that is common language.

Senator MURRAY. That applies in every bill, every act that is passed by the Congress. You have somewhat similar language with reference to every agency that has been established in Washington. It has to be under the direction and supervision of someone, and the law usually provides language of that kind.

Senator DONNELL. That is what this language is, at any rate, and whether or not it is justified is a matter, of course, for argument.

Now Mr. Cruikshank, we have thus far developed the fact, with your concurrence, as I understand it, about the support of this system coming from governmental funds arrived at and derived in the manner indicated; the fact that the national health insurance board is to be created, that it in turn is under the direction and supervision of a Federal official, the Federal Security Administrator.

Now you have said there are certain limitations and so forth. I have quoted the language and you have agreed that this language is in the act, whether or not you arrived at the same conclusion that I did, being another question.

Mr. CRUIKSHANK. Well, I certainly do not.

Senator DONNELL. All right. Now I call your attention at page 118 of the act, section 718, to this:

> Agreements for the furnishing of medical or dental services shall provide for payment—

You see that in the act?

Mr. CRUIKSHANK. That is right.

Senator DONNELL. And among other payments are the basis of fees for services rendered, on a per capita basis, on a salary basis, on such combinations or modifications of these bases as may be approved by the State agency. You observe all that?

Mr. CRUIKSHANK. Yes, sir.

Senator DONNELL. Now I call your attention to section 717 (a), the section immediately preceding, which says:

> Each agreement made under this part—

I take it we would agree that section 718 (a) is under the part mentioned in section 717 (a); is it not?

Mr. CRUIKSHANK. Yes; it is.

Senator DONNELL (reading):

> Each agreement made under this part shall specify the class or classes of services to be furnished or provided pursuant to its terms, shall contain an undertaking to comply with this title and with regulations prescribed thereunder.

You observe that, do you not?

Mr. CRUIKSHANK. Yes, sir.

Senator DONNELL. So that I take it you would agree the agreements stand for the furnishing of medical or dental services other than specialist services which appears under section 717–718 (a) is to be made and contain an undertaking with regulations prescribed under this title. That is right; is it not?

Mr. CRUIKSHANK. That is correct.

Senator DONNELL. Do you think, Mr. Cruikshank, that where you raise the money from the Government, where a Government board operates, where that board operates under the direction and supervision of a governmental official, where it is provided that the agreements for the furnishing of the various professional services which I have indicated here shall be made subject to the regulations which shall be made under this title of the bill, do you think that that is free from the idea of socialization of medicine?

Mr. CRUIKSHANK. Completely free from it; yes, sir. That is the way the American people operate. In back of some of these questions there is a kind of concept about the Government being removed and different from the people themselves.

We have had many experiences with various kinds of Government agencies. Some of them are rather arbitrary like those that operate under the Taft-Hartley Act. Others are very responsive to the needs of the people whose interests they represent, and we see in this measure every attempt to keep these programs and these regulations directed toward the purposes as stated in the bill.

Now in that very section that you cited on 718 there is even the provision following those which you cite that—

> another method or methods of payment (from among the methods listed in this subsection) to those medical practitioners or to those dental practitioners who do not elect the method of such majority, when it is found that such alternative method of making payments contributes to carrying out the provisions of section 735 of this title or otherwise promotes the efficient and economical provision of medical or dental services in the area.

That is even after all the local participation and the recommendation of these rules and recommendations at the local level of administration, if there is a group that finds that it is not acceptable, then they are required to include those in the plan, so there is every bit of elasticity that can be devised in a Federal statute incorporated in this for the participation of the practitioners and the people who are covered by the act.

Senator Donnell. You read the language "when it is found that such alternative method of seeking payments contributes," and so forth. Who makes that finding?

Mr. Cruikshank. Well, it would have to go through the State plan; yes, sir.

Senator Donnell. Do you think it would have to go through the Federal plan also, through the National Health Insurance Board?

Mr. Cruikshank. It finally would; yes.

Senator Donnell. And finally through the Federal Security Administrator. That is correct, is it not?

Mr. Cruikshank. That is right.

Senator Donnell. Now turn, while you are on that page, to page 119, Mr. Cruikshank, if you will, please.

Senator Murray. Before you leave that point, I would like to point this out. Do not the other bills that undertake to provide a more or less comprehensive system of medical care have similar provisions? I note that the bill which is to be filed in the Senate today and is known in the press as the Republican bill, contains language somewhat similar to this. Here is section 1711 (a):

> The Surgeon General is authorized to make such administrative regulations and perform such other functions as he finds necessary to carry out the provisions of this title. Any such regulation shall be subject to the approval of the Administrator.
>
> (b) Administering the provisions of this title the Surgeon General with the approval of the Administrator is authorized to utilize the services and facilities of any executive department in accordance with an agreement with the head thereof—

and it goes along in other provisions of the act along the same line.

Mr. Cruickshank. You have to place final responsibility, do you not, Senator on an administrator if you are going to place any check on the program at all?

Senator DONNELL. Mr. Cruikshank, the point that I am getting at is this. You say that this is not a socialization of medicine. You say that the executive board says that—

> We have no desire to socialize the practice of medicine.

Mr. CRUIKSHANK. That is right.

Senator DONNELL. Yet we have a governmental plan worked out here for the raising of revenue with which to pay the expenses of what is termed here "prepaid personal health insurance benefits," all operated by the Government.

I understand about the local participation, but I pointed out the fact that the regulations of the local administration must be subject to and in harmony with the bill, and likewise I think are governed by the regulations made by the national administration heading up into the Social Security Administrator.

Now what I am trying to do is to point out in this record—whether you agree with it or not, and I doubt if you do agree with it: I do not think you do, from what you have stated, but I want to point out in this record—as having something to do with the statement of the American Federation of Labor, that it has no desire to socialize the practice of medicine, what seems to me very clear, taking over functions that are now handled by doctors and hospitals themselves and are to be taken over under this bill by the Government itself acting under these various agencies.

Now you may be quite right that ultimately somewhere the authority has to rest. I am not questioning that point, but the point is that this bill very clearly does invest ultimate authority in the Government in the management of this whole plan.

I referred to the hospitals a little while ago. I did not go into detail on that, but if you will turn to page 119 to which I was about to direct your attention when Senator Murray asked his question, you will not down on the bottom of that page:

> Agreements for the furnishing of hospital services as benefits under this title shall provide for payment on the basis of the reasonable costs of hospitalization furnished as benefits: *Provided*, That the Board—

now that is this National Health Insurance Board, as I understand it—

> after consultation with the advisory council and with representatives of interested hospital organizations—

the Board—

> may by regulation prescribe maximum rates for hospitalization furnished as benefits under this title, and such maximum rates may be varied according to causes of localities or types of service.

That is the language, is it not, in the bill?

Mr. CRUIKSHANK. That is right.

Senator DONNELL. Now without debating as to whether that justifies the conclusion that that is another step toward socialization, I simply want the record to show at this point these successive steps, and I will not burden you by going into other steps which I have developed in somewhat greater detail a few days ago by another witness.

Mr. CRUIKSHANK. Well, Senator, may I just comment on that, because I think your comments and questions are related to this quoted section from the statement of the executive council?

Senator DONNELL. Yes, sir.

Mr. CRUIKSHANK. And this quotation is taken without the break, incidentally. The second paragraph of the quotation is without break from the first paragraph.

They had before them S. 1606 which had this identical provision in it, and they pointed out; that is, with those provisions before them it is quite apparent that they did not consider that those were steps toward socialization because what they are saying here is, "We have no desire to socialize the practice of medicine, but we agree that it is entirely feasible to spread the risk of the cost of illness," and so forth, and they then go on to give this approval of S. 1606 which had this same provision in it.

Now it is not only my opinion but it is the opinion of my organization that that is not a socialization of medicine.

Senator DONNELL. Very well, I understood it in this report of the executive council, just as you say, that they say, "We have no desire to socialize the practice of medicine."

The points that I desire to bring out are certain facts which it seems to me very strongly demonstrate the fact that this bill, S. 1679, contains step after step after step after step of a nature that justifies he view that this is a socialization of the medical services referred to in the bill. Now you do not agree to that.

Mr. CRUIKSHANK. That is your position, Senator, that it does.

Senator DONNELL. I think it does.

Senator MURRAY. Well, did not Senator Taft here the other day say that he had no objection to socialization except that he does not want it to go beyond the 20 percent?

Senator DONNELL. I do not recall any statement of that kind by Senator Taft about having no objection to socialization. At any rate, each one of us has his own right of expression and his own view.

Do you think what you might justly term socialized medicine exists today in England?

Mr. CRUIKSHANK. Yes, I think the present program in England is a part of their whole nationalization program which is socialization in one sense. You always have to be careful how you use that term, but I think it could be said that it is a socialized program to some extent.

Senator DONNELL. In what respect do you think that the English system at the present time contains elements that makes it socialized medicine, whereas this bill, S. 1679, would not in your opinion be socialized medicine?

Mr. CRUIKSHANK. Because the English system at the present time has gone away from the contributory insurance system, and it is supported completely out of the general revenues of Government.

Senator DONNELL. You think the support out of the general revenues makes it a socialiation, is that it?

Mr. CRUIKSHANK. I think the support out of general revenues, the complete support out of general revenues and the departure from the contributory system of social insurance makes a very important difference.

I am sure that my organization has never endorsed a program remotely approaching that of the English program today. I do not think that this program is completely socialized in the sense that, for instance, they have contemplated socializing the steel industry in England because there is too wide a variation allowable for private differences in income of the doctors. They have not put them on a direct salary basis as they have their coal board, the transportation board, and as they contemplate the steel board.

Senator DONNELL. Have you read the law in England under which their system is now operating?

Mr. CRUIKSHANK. Yes.

Senator DONNELL. Very well, that is all, Mr. Chairman.

Senator MURRAY. Thank you, Mr. Cruikshank.

We will recess now until 2 o'clock.

(Whereupon, at 12:50 p. m., the hearing was recessed to reconvene at 2 p. m. this same day.)

The subcommittee reconvened at 2:45 p. m., at the expiration of the recess.

Senator MURRAY. We will proceed now, and you may take the stand.

STATEMENT OF PAUL R. HAWLEY, M. D., CHIEF EXECUTIVE OFFICER, BLUE CROSS-BLUE SHIELD COMMISSIONS

Dr. HAWLEY. Mr. Chairman, I am Dr. Hawley, from Chicago, associated with Blue Cross and Blue Shield Commissions.

I appear before you as a representative of the Blue Cross Commission of the American Hospital Association and of the Blue Shield Commission of Associated Medical Care Plans. However, I shall speak primarily as a citizen who has long been interested in good medical care for our people.

Mr. E. A. van Steenwyk, the executive director of Associated Hospital Service of Philadelphia, will follow me and speak upon the contributions of Blue Cross to the health of the Nation, and of the advantages of the voluntary over the compulsory method of approach to our citizens. Mr. van Steenwyk is one of the most experienced administrators in the field of voluntary prepayment of the costs of health care, and an elder statesman of Blue Cross.

As regards S. 1679, this bill proposes a long leap into the welfare state. I am not saying that this is either right or wrong. This is a decision that each citizen must make for himself. But no one should be deceived, either by himself or by others, as to the nature of the program presented in this bill.

I cannot help being disturbed by the glib statements that appear in the declaration of purpose and declaration of policy in this bill—statements that cannot be supported by any facts known at the present, and some that are palpably untrue.

To select only a few, the statement that the "vast majority" of our people are unable to meet the shattering cost of serious illness is contrary to well-known facts. If this were true, there would be a small market for automobiles, for refrigerators, for tobacco, for moving pictures, and for many other luxury items that are purchased regularly by the great majority of our people.

The charge for protection against the cost of serious acute illness for an entire family, regardless of size, is not more than the cost of one package of cigarettes per day. That Government must subsidize, in whole or in part, the care of illnesses of long duration has been recognized for generations.

That the shortage of physicians and hospitals is critical is a gross exaggeration. It is true that there can be some improvement in the distribution of physicians, but recent studies have shown that maldistribution is not nearly so serious as has been claimed. Some increase in the number of physicians would be beneficial, particularly to permit of the diversion of more of them from active practice to the fields of education and public health.

However, compulsory health insurance will exert to influence either upon the number or the distribution of physicians. It is not limitation of income which discourages physicians from practicing in agricultural areas. Considering overhead and cost of living, most rural physicians are better off financially than the average urban practitioner. Physicians know this; and it is the lack of diagnostic facilities in many rural areas, without which the young physician cannot practice the standard of medicine which he has been taught, which deters him from settling there. Compulsory health insurance will not provide these facilities; their cost must be met through general taxation regardless of the method of payment for medical care.

The replacement of obsolete and obsolescent hospitals is also indicated. In some areas there is need for more hospital beds. Other areas are already overbuilt. There is, however, grave doubt among the experienced people in this field that a considerable increase in the total number of hospital beds in this country can be justified upon the grounds of need; and there is a very great danger in constructing hospitals in places where professional skills are not adequate for serious surgery.

Neither it is true that the provision for the health needs of farm families is "wholly inadequate." As I have just indicated, there are areas in which this provision can and must be improved; but to imply that this inadequacy is general is to create an inference that simply is not true.

The implication that medical research is being seriously retarded because of inadequate financing is not in accordance with fact. To suggest that medical facilities and personnel should be distributed according to population and geographical expanse is to display ignorance of what constitutes good medical care. The most expert medical care will always be given in medical centers. It can never be made available locally in every hamlet; and the most important thing is to be certain that people in rural areas, when in need of specialist care, can reach the medical centers where the finest talent will always be concentrated, regardless of any legislation to the contrary.

To state categorically that these deficiencies can be remedied only through a drastic change in the present system of payment for medical care is to display a colossal lack of understanding of the task before us. Such statements are characteristic of the demagoguery which has substituted for statesmanship in much of the discussion of this issue.

We must, rather, train more technical and professional personnel, learn to integrate the use of our present complex facilities to the needs of the individual patient and, most difficult of all, teach the public to use and not to abuse what is already available, and to avoid the invitation of this bill to pill-swallowing hypochondriacs. I do not know whether or not voluntary methods will be able to correct all of the deficiencies in our health program; but there is every evidence at present that they will meet all reasonable requirements in the field of prepayment of the costs of medical care.

One might have expected that the Declaration of Purpose in S. 1679 would have included such exploded arguments as that 5,000,000 Americans were rejected for military service in World War II because of disabilities which were easily preventable with good medical care, and that several hundred thousand die each year in this country because they are unable to pay for good medical care. Such statements are still made by the proponents of compulsory health insurance despite the fact that they have been thoroughly discredited.

Mr. Cruikshank made a statement to that effect this morning, that many people die in this country because they are financially unable to obtain good medical care; and furthermore, he misrepresented—I do not think willfully at all—the benefits under the voluntary plans.

On the other hand, not all the arguments used against compulsory health insurance are convincing. The real truth is that there are entirely too few facts available for anyone to form a fixed opinion. I can conceive of no greater folly than either to accept at this time the necessity for such a radical step as compulsory health insurance, or to reject it for all time. The wisdom of seeking more facts before acting would seem to be incontestable.

I therefore urge this committee to initiate the creation of a fact-finding body to thoroughly explore the situation and report to the Congress and the American people. The public reception of the work of the Commission on the Reorganization of the Executive Branch of the Government—the Hoover Commission—is evidence that the people have confidence in the findings of an impartial group of able men. This Congress could do not greater public service than to provide for the appointment of a similar commission to examine this problem and to recommend an aggressive program of action toward a solution.

It is interesting to note that previous enactments of Congress are responsible for the existence of some of the deficiencies listed in this bill. These have largely dried up the sources of voluntary support of medical education, and they have reduced to an all-time low the income from endowments. Having created some part of these problems, it is now proposed further to stifle voluntary effort in this country and to intrude Government into the most intimate details of our private lives. The assurance of freedom in medical education and practice is a pious pronouncement that is contradicted both within the bill and by the history of all previous excursions of the Government into matters of this nature.

Paragraph (b) (1) of section 372, which provides for payments to schools for costs of instruction of health personnel, is a most dangerous proposal. It is a well-known fact in educational circles that too many medical schools today are attempting to educate more students than are compatible with training of the highest quality. The need is for more medical schools, yet this provision of the bill is a bribe offered to struggling schools further to sacrifice quality for quantity.

Medicine is one vocation to which the principles of mass production cannot be successfully applied; nevertheless, this bill offers pitifully small inducement to schools which elect to do a first-class job with fewer students, dangling before the starved eyes of medical educators the temptation to abandon quality for volume. One cannot but wonder whether the great disparity among the inducements offered by this bill to the several fields of professional education is a reflection of relative need or of anticipated resistance to temptation.

As regards title VII of S. 1679, "Prepaid personal health insurance benefits," there are only two considerations to be weighed. The least important of these is the cost. If the advantages to be gained were worth the cost, there would seem to be no reason for the careful concealment of the estimated cost of the national health insurance—not that such a statement would be appropriate in this bill; but it would certainly be appropriate if the proponents of this legislation, especially those within the Federal Security Administration, would take the people into their confidence to this extent, a public responsibility which they have thus far avoided.

I do not know exactly what national health insurance will cost the Nation, but I do know, and state positively, that it will cost a vast amount more than the 3-percent of wages which has been put forth as paying for this program in whole or in large part. This is, of course, known to the framers of this legislation, who have provided for additional appropriations from the general revenues of the Government.

It does not require much experience in the field of health insurance to realize that the benefits outlined in section 701 of this bill, "Classes of personal health services," will cost at least three or four times the amounts provided in the most liberal of the voluntary nonprofit prepayment plans. Since there can be no protection erected against abuse of the privilege of unlimited home and office calls, efforts to offer such services by voluntary insurance have proved to be more costly than the average family cares to share. This is the present experience in England, as all observers have noted, even as sympathetic an observer as Hugh Leavell.

This feature alone would absorb most of the 3 percent of wages. To this service, add periodic medical examinations, and dental and nursing service—all in excess of the coverage provided by voluntary nonprofit plans—and one can state confidently, supported by the accumulated experience of years, that the cost of this program will not be less than, and may well be more than, $100 per beneficiary per year. Competent economists, working independently and from other bases, have arrived at the same estimate. There is not the slightest doubt in my mind but that this estimate is reasonable. It might prove illuminating if the experts in the Federal Security Administration could be persuaded to offer their estimate.

One estimate has been given by the proponents of compulsory health insurance. This is that, with our present population, the income from the 3-percent tax on wages will not exceed 6 billion dollars when all wage earners are covered in a period of full employment. It is evident, then, that the annual deficit to be met from general revenues will be at least 6 billion dollars annually if only 120 million people are covered, and 9 billion dollars if all of our people are covered.

I am no economist; but, as an average citizen, I am unable to understand the thinking that would shoulder such a huge additional burden upon the American taxpayer, already struggling to meet his contributions to foreign aid, national security, and the carrying charges upon a national debt of astronomical proportions. This will be his added burden during times of prosperity. I wonder whether it will not crush him completely during the first period of depression.

Health is a most important national asset. But it is by no means the only important asset, and it is closely related to others. If, through excessive expenditures upon health, a crippling burden is placed upon the budget of the Government, the stated objective of S. 1679 will be defeated. The best medical care in the world cannot maintain good health if handicapped by a general depression arising out of confiscatory taxation.

While I repeat that the cost is not of the most important consideration, I marvel at those in public life who appear to disregard it entirely. But this, of course, is a very old principle of socialism—first to tax to the point of strangulation and then to redistribute the earnings of citizens through an omniscient government.

What concerns me most about compulsory health insurance is its effect upon the quality of medical care. This effect has been demonstrated in every country in which it has been tried.

During the last half of the nineteenth century, the world capital of medicine was in Germany. Doctors the world over went to Germany to complete their training. The program of compulsory health insurance was the greatest factor in the loss of this preeminent position. Today the world capital of medicine is in the United States. It will be the greatest tragedy in the world if the quality of medical care in this country is offered as a sacrifice to political expediency.

The members of this committee who were Members of the Seventy-ninth and Eightieth Congresses may recall that my efforts in behalf of veterans were directed primarily toward elevating the quality of medical care given them; and toward increasing the amount of medical care available to them only when quality could be assured. I resisted all efforts, not always successfully, however, to increase quantity at the expense of quality. I do not need to mention the success of this policy. By and large, veterans are now receiving medical care of the highest quality. This would not have been the case had I supported the demands for the operation of hundreds of additional veterans' hospitals.

Medical care is not primarily a matter of buildings or of money. It is a product of the competency and the zeal of the professional personnel who alone can provide it. I think these factors have been overlooked entirely in S. 1679.

Both the proponents and opponents of compulsory health insurance are agreed upon at least one point—that the present facilities for providing medical care in this country are no more than adequate for the present load, and some say inadequate. The experience of every compulsory health-insurance program ever attempted has been that the demand for medical attention is greatly increased and that this increase is largely in the realm of inconsequential ailments which people ordinarily disregard—and the health of our people as a whole would be improved if these were disregarded oftener.

The only way by which a limited amount of anything can be spread more widely is by dilution. Any increased demand upon facilities for medical care, already barely able to meet the existing need, can have only one result—that patients in real need of expert medical care must be neglected in order that the facilities be shared with those demanding attention for complaints of little consequence, real or fancied. This is the experience in England today. Even the observers, who are biased in favor of compulsory health insurance, report the long delays that must be endured by those in urgent need of medical care.

If proponents of compulsory health insurance were sincere in an effort to improve the health of the Nation, they would advocate that facilities first be increased in order that the demand be met. They would insist upon being able to provide everything that they promise. The conclusion is inescapable, however, that to these people compulsory health insurance is not a means to an end, but the end in itself.

Compulsory health insurance has been described as "socialized medicine." "Socialized medicine" is a term which cannot be precisely defined. Perhaps this is why the proponents of compulsory health insurance have now adopted it to denounce other bills before this Congress which have been offered in an effort to solve our health problems through voluntary means—a device reminiscent of childhood when sometimes the only retort to an epithet, producible in the confusion of the moment, was, "You're another."

Whether S. 1679, or S. 1106, or S. 1456, or S. 1581 are "socialized medicine" can be argued indefinitely; but one thing past all argument is that S. 1679 is definitely "socialization of medical care." Whether this be good or evil is another matter; but it is a fact which should be clearly recognized.

Mr. Cruikshank stated this morning that the reason the present system in England was not socialized medicine was because there were no direct contributions, that it was entirely supported out of taxes.

That is not true. There is a direct contribution of the beneficiaries to their medical care program. It is largely supported, but not wholly supported, by taxation in England.

Senator MURRAY. Doctor, at that point could you give us your definition of "socialized medicine"?

Dr. HAWLEY. Yes, I will give a broad definition: That it is an effort to distribute any kind of a benefit equally without regard to contribution or productivity.

Senator MURRAY. It seems to me that this is a glittering generality. It seems to me you ought to be able to give us——

Dr. HAWLEY. If I am guilty of that, sir, Noah Webster was first guilty of it. That is, I think, a general definition of "socialization." Anything which distributes medical care, or whether it be anything else, on any basis other than a basis of contribution through insurance, through anything else, I think is definitely socialization.

I am sorry if my definition is not accurate or clear, but that is my understanding of it.

Senator MURRAY. That is the trouble. There is so much propaganda used in the country with reference to this subject that a lot of the people are confused.

We do not consider this as socialized medicine at all, as the description of socialized medicine has been given to me. But I notice that you can hardly pick up a daily newspaper but what you see an effort to confuse the public on this.

I have a clipping here from one of our local papers in which they tell about the National Fraternal Congress of America—whatever that is—issuing a resolution which has been distributed across the country. The resolution goes on to say:

> Whereas socialized medicine has been defined by Oscar Ewing, Federal Security Administrator as follows: "Socialized medicine means that the doctors are salaried employees of the Government; as their employer the Government can direct and control any detail of their work, all medical services are controlled by the Government, and medical care is furnished to citizens through the Government."

Then it goes on with other misrepresentations and misstatements with reference to it, and to give out the idea to the American people that that is the program that Oscar Ewing is proposing to the American people.

You do not agree with that?

Dr. Hawley. No, I do not agree with that. I do not agree with that at all.

Senator, if you remember, I said I could not define "socialized medicine." I did not know what the words "socialized medicine" meant. I said that the distribution of medical care upon any principles as set forth in S. 1679 was the socialization of medical care. Whether that be socialized medicine or not, I think we could argue indefinitely.

Senator Murray. Are you against all socialization of problems that we have in this country? Are you against unemployment compensation, for instance?

Dr. Hawley. No, sir.

Senator Murray. Unemployment insurance?

Dr. Hawley. No.

Senator Murray. Are you against workmen's compensation?

Dr. Hawley. No, sir. I am against the administration of much of the social insurance in this country. I am not against the principle. I am against the abuses and I am against some of its byproducts.

Senator Murray. You recognize, do you not, that a large percentage of the American people are unable to meet the cost of serious illness. The American Medical Association has put out a statement to the effect that people living on an income of less than $3,000 a year would be unable to meet the cost of serious illness. That statement was issued some years ago, and if brought up to date, it would mean that people living on an income of less than $5,000 are unable to care for a serious illness.

Dr. Hawley. Senator, perhaps I do not accept that authority any more than do you. But that statement was made at a time when there was no widespread means of meeting that cost through insurance. I will agree with you right now that without insurance, anyone, the head of a family, the family income of which does not exceed $5,000 a year, is not ordinarily financially able to meet the cost of serious illness out of his own savings and money at hand. I agree thoroughly with that.

Senator Murray. What are you going to do for those people that are in that situation?

Dr. Hawley. Because I think anyone with an income of even less than $5,000 a year can well afford, within the family budget, to protect themselves with voluntary insurance against the cost of serious illness, I will accept that distinction all the way through, that there is great necessity for means of protection against the cost of serious illness.

Senator MURRAY. But we find in this country that the average family that has no illness at the outset does not make provision of that kind because it is so beset with the other problems, such as housing and the education of their children, clothing of their children, and other needs for the family, that they find it difficult, if not impossible, to set aside funds to take care of illness that may come in the future.

Dr. HAWLEY. Senator, I think the growth of the voluntary nonprofit plans would not support that. I think that the fact that as of the 31st of March Blue Cross passed the 34,000,000 mark does not support the statement that there are many people who cannot afford to protect themselves against the cost of serious illness. I think you would have to go up to an income of $10,000 a year before you would get a family that could afford to carry protection against the cost, the complete cost of medical, dental and nursing care on an insurance basis, unsubsidized heavily. It would take wealthy people to carry insurance like that.

Senator MURRAY. If that is the situation, do you not think there is a great need in this country to find some way of meeting that problem?

Dr. HAWLEY. Yes, sir.

Senator MURRAY. Are we going to sit by——

Dr. HAWLEY. No.

Senator MURRAY. And allow people to be bankrupted when they meet with a serious illness?

Dr. HAWLEY. No, sir; I agree with you, there is great need.

Senator MURRAY. They have been talking around here now for the last 10 or 12 years about what voluntary medicine will do, but the American Medical Association itself, after having given some study to the matter some years ago, said that voluntary system will never prove adequate, that if we are going to have any kind of insurance it must be compulsory.

Now, that statement was made by the American Medical Association itself at one time.

Dr. HAWLEY. I do not suppose it would weaken the validity of that statement, sir, if I did not agree with it.

Senator MURRAY. I am glad to have you frankly admit that you do not agree with the American Medical Association in any of these problems. I think you have had experience yourself with them, and I think that if you would give a little more careful study to the program that we have presented here in S. 1679, that you would not speak so disparagingly of it.

Dr. HAWLEY. It could be, sir. I have studied the matter pretty carefully, and each time I go over it I seem to be a little more opposed to it.

Senator MURRAY. I am inclined to think that you are continuing to read literature sent out by the American Medical Association and its propagandist organization. It seems to me that what you are saying is merely a denunciation of it without presenting facts.

Senator TAFT. You just read the bill more carefully every day; is that it?

Dr. HAWLEY. Yes.

Senator PEPPER. It cannot be that you are slipping, can it?

Dr. HAWLEY. Am I slipping?

Senator PEPPER. I say, it could not be that you are slipping?

Dr. HAWLEY. I am accused of that. I will soon be eligible for old-age and survivors insurance. Perhaps I am one of the 600,000 people who suddenly became 65 in this country so they could get it.

Senator TAFT. General Hawley, I know that you suggested one package of cigarettes a day would pay for medical insurance.

Dr. HAWLEY. Yes, sir; against the cost of acute illness.

Senator TAFT. How much is the cost of voluntary insurance for a family of four?

Dr. HAWLEY. Well, you quoted the Michigan plan this morning. That runs between $72 and $80 a year, and that is both medical and hospital, and that is 120 days of hospitalization in a year, more than this bill provides.

Senator TAFT. I was interested. I wanted to use it as a very useful comparison. You figure that 365 days, at 20 cents a package, would be $73 a year, would it not, for one package of cigarettes a day?

Dr. HAWLEY. If you want to stretch that a little further, that would also protect a family of 10. There is no distinction in that plan. It is a family.

Senator MURRAY. There are a lot of people that do not smoke cigarettes, so what are they going to do? What would you say they should do, Doctor?

Senator TAFT. He is not suggesting that you give up cigarettes.

Senator MURRAY. Should they stop going to a movie theater? Should they stop having a little vacation each year? Or should they stop sending their children through college when they get through high school?

Dr. HAWLEY. Senator, without any effort to be facetious, I have found that people who do not smoke cigarettes have other bad habits that they could give up.

Senator MURRAY. I smoke cigars. I do not smoke cigarettes, and they are more expensive, and I do not want to give them up, either.

Dr. HAWLEY. Senator, S. 1679 protests that among its objectives is the preservation of the freedom of medical practice. It forces concurrence of all practitioners in the method of payment for services voted by a bare majority of their fellows—with the unworkable sop that alternative methods may also be approved if such be more efficient and cheaper.

Thus the minority, regardless of size, is denied protection—a new principle of Government in this country. It reduces compensation to a common level, regardless of the individual expertness of the practitioner—a level fixed by the Government and not by those who must furnish the service. Once entering upon an agreement to furnish services under S. 1679, the practitioner is compelled to continue this agreement during the will and pleasure of the Government. This smacks of peonage, and I doubt that this provision, which is section 702 (a), is constitutional.

The provision for utilization of voluntary plans has obviously been inserted for political effect. No informed person believes that it would be possible for a voluntary plan to exist in such a program.

S. 1106, S. 1456, and S. 1581 all offer a remedy for one or another of the deficiencies in our health program. Each has considerable merit. For one thing, their philosophy is in the American tradition as opposed to the concept of the welfare state. For another thing, they attack individual deficiencies in an orderly manner—providing for such benefits as can be assured with present limited facilities and for the expansion of these facilities, rather than being omnibus proposals for the building of the roof at the same time that the foundation is laid.

S. 1106 would provide for the need which is perhaps the most pressing of all—the rapid extension of diagnostic services. If this need were met, a much healthier redistribution of physicians would occur automatically. It is generally recognized that the lack of adequate diagnostic facilities is the most potent factor in the shortage of physicians in certain areas.

S. 1456 removes all outward evidence of charity, which seems now, by a distortion of the meaning of the word, to have become a mark of opprobrium instead of one of the three abiding virtues enumerated by St. Paul. In contrast with S. 1679, this bill is sincere in its proposal to encourage the extension of the voluntary principle of prepayment of the costs of medical care. One of its most important provisions is that for the continuance of payment of the cost of voluntary insurance during periods of unemployment.

I was interested this morning in the discussion of the means test and of the adamant stand of labor against it. One swallow does not make a summer at all. But as I heard that discussion, I thought of an evening 3 weeks ago when I appeared before the Shiel School of Labor Relations in Chicago, discussing this question of voluntary insurance, and the moderator of the evening was an officer of a union in the American Federation of Labor.

He told me as a matter of information and fact, that in administering strike benefits in his union, he had been approached by one of the striking members for strike benefits. He inquired of this member, "How much money have you got in the bank?" The member told him "$3,500." And to quote almost exactly his words, "I said, 'Get out of here; we are giving our money to the men who need it to get along during this.' "

Now, I do not offer that as any widespread use of the means test, but here, right within the ranks of people who are objecting so strongly to this, is one example at least of the application of it.

Senator MURRAY. You do not feel that there is any real objection to the means test?

Dr. HAWLEY. No, I do not feel that there is any objection to it. I might say that if there were any rational, reasonable way to do away with it, I would do away with it.

Senator MURRAY. I notice that the only people who seem to think it is all right are people who will never have to meet the problem. I have not heard anybody from the ranks where they may be required to meet the test commending it. It is only people who are in a very satisfactory situation that seem to think that it is all right.

Dr. HAWLEY. Senator, I served 30 years in the Army under the pay schedule set up by this Congress, and I faced the means test every day. We have all got to face a means test.

Senator PEPPER. You got your medical care, though, at the time you were in the Army, did you not?

Dr. HAWLEY. I did not get half as much as I gave.

Senator PEPPER. But it was available for you. Practically all your professional life were you not able to go to a hospital, get a doctor, or a dentist, or a nurse, without having to dig up out of your salary to pay for it?

Dr. Hawley. That is right, most of the time.

Senator Murray. Do you think it is wrong for some segments of our population to have free medical care?

Dr. Hawley. No.

Senator Murray. You think that is all right?

Dr. Hawley. Yes, sir.

Senator Murray. You approve of the situation here in the Senate where the Senators all get free medical care and have a clinic right here in the building and go out to the big fancy hospitals and get well provided for in case of illness?

Dr. Hawley. Senator, if I did not approve of it, I would not say so here, at least.

Senator Murray. Very well.

Dr. Hawley. S. 1581 also recognizes that the problem of assistance in the expansion of health facilities is in nowise associated with the question of the proper method of prepaying the costs of medical care. Despite the implication in S. 1679 that compulsory health insurance is essential to the improvement of facilities for medical care, no thinking person will be deceived upon this point.

Every penny of the money for increase of facilities, and every penny that goes to pay for the medical care of the indigent, must come from the general revenues of the Government, for the simple reason that the revenues from pay-roll deductions and employer contributions will fall far short of paying for the benefits in part B of title VII of S. 1679, even in the highest income group. S. 1581 recognizes this and avoids the specious sham of S. 1679. If this bill possessed no other virtue, that is, S. 1581, it can boast of an honest and realistic approach to the problem.

I should like to summarize my testimony as follows:

First, the most important consideration in this issue is the preservation of the present high quality of medical care in this country, and encouragement of its improvement in the future. Throwing an additional burden upon present facilities, before they can be expanded, will do exactly the opposite. It will inevitably lower the quality of medical care through dilution of time and effort.

Second, the only realistic approach to the creation of compulsory health insurance is to increase the facilities before the extra demand is added. Compulsory health insurance is in nowise essential to this "tooling up" period; and the fact that it is given first priority in the program of S. 1679 is evidence that it is the goal of the proponents, rather than a means of attaining the goal of better health.

Third, the cost of title VII of S. 1679—Prepaid Personal Health Insurance Benefits—will be prohibitive in all but periods of maximum employment and production. It will threaten the military security of the Nation through forced reduction of funds for defense; and it holds the promise of wrecking the solvency of the Government. That is if all the benefits are provided, not if there is a limitation to the Government's contribution. If there is a limitation, then all the benefits cannot be provided.

Fourth, less than one-half the cost of title VII of S. 1679—Prepaid Personal Health Insurance Benefits—will be met by direct contributions, even in the most optimum periods. In periods of economic depression, the cost cannot be met without the discontinuance of essential departments of Government or through deficit financing. The size of the present national debt should discourage the initiation of other unlimited commitments which are not self-supporting.

Fifth, the cost of increasing the facilities for medical care must be met entirely from the general revenues of the Government. Such a program can be accelerated or decelerated as indicated by the financial condition of the country at any particular time. It does not commit the Nation to a fixed charge forever, a charge that may become insupportable but inescapable.

Sixth, S. 1106, S. 1456, and S. 1581 recognize the existence of correctible deficiencies in the health program, the correction of which depends in no way whatsoever upon the enactment of compulsory health legislation. They would correct these deficiencies one at a time, reserving the opportunity to discontinue an experiment which proved unsuccessful, rather than to commit the Nation to an irrevocable step which experience in other countries has proved far from attractive.

Seventh, the greatest contribution this Congress can make, and the only one dictated by wisdom, is to create an impartial commission of able citizens to explore all ramifications of the health problem, to report the facts, and to recommend action.

Senator MURRAY. Doctor, in this country there seems to be a policy of requiring each industry in the country to stand on its own legs and provide for the costs of taking care of any problems that develop in that industry. Do you approve of that?

Dr. HAWLEY. Yes, I would approve of that, except that there has been considerable departure from that principle by the Congress, Senator.

Senator MURRAY. But you said the basic policy should be that each industry should support itself and not come to Congress for subsidies.

Dr. HAWLEY. I would hope that that could be true.

Senator MURRAY. For instance, in the mining industry, if they find difficulties in underground mining where they have dust or problems, silicosis and so forth, you think that the industry itself should take care of that situation?

Dr. HAWLEY. Well, yes, I would say so; but I do not know where you are leading me to here.

Senator MURRAY. That is all right. I am not leading you at all. I am just asking you a few simple questions. I am just a simple country boy from Montana, and I am not very smart on cross-examining like some of our very able Senators here; and you need not worry about my questions.

Dr. HAWLEY. You see, I come from a more backward State than that, Senator. No, no, I would agree with that. That would be the better way of handling the problem.

Senator MURRAY. And that applies to every industry?

Dr. HAWLEY. Yes.

Senator MURRAY. Now, in the coal-mining industry, John L. Lewis is seeking to provide for the health and care and protection of his employees by requiring the industry to put up the money necessary to provide them with good health care, hospitalization. Do you approve of that?

Dr. HAWLEY. No, sir.

Senator MURRAY. You do not approve of that?

Dr. HAWLEY. No.

Senator MURRAY. Now then, the medical profession is a profession that is made up of men that make a pretty substantial income. Do you think that it is proper for us to provide them with all the facilities for their work and their operations at Government cost and allow them to make incomes sometimes as high as $200,000 a year, because of a situation where the Government provides these facilities?

Do you approve of that?

Dr. HAWLEY. No, I do not approve of that as a principle of Government.

Senator MURRAY. You think the medical men should build their own hospitals and provide their own clinics?

Dr. HAWLEY. No, I do not agree with that.

Senator MURRAY. By having the Government do it, that makes it very easy for them to make huge incomes out of the practice of their profession.

Senator PEPPER. A lawyer does not have his books or office provided, does he?

Dr. HAWLEY. Of course, the lawyers have easier ways of making money, Senator.

Senator PEPPER. If they get a little, they get cut out of them by the doctors, generally.

Dr. HAWLEY. We are getting entirely away from the entire theory upon which medical care has been built, you see. Medical care from time immemorial has been subsidized by voluntary contributions. People supported hospitals. They built hospitals by private contributions.

And so the entire structure of medical care has been built on subsidization, particularly in the care of the lower-income groups.

Now that there is no money to be contributed to this, I think it is a necessity, however hard it would be for me to swallow, that we have got to turn to Government for this subsidization which has always been given heretofore by voluntary contributions.

Senator MURRAY. You think it was unfortunate that we had to change that system?

Dr. HAWLEY. I think it was very unfortunate, yes, sir.

Senator MURRAY. You do not believe in the income-tax policy of this country?

Dr. HAWLEY. Well now, that is a broad statement. I believe in certain limits to it, and I am becoming more convinced each year about those.

Senator MURRAY. You say here in your statement:

> It is interesting to note that previous enactments of Congress are responsible for the existence of some of the deficiences listed in this bill.

What do you mean by that?

Dr. HAWLEY. I mean they have dried up the sources of contributions, and that it is the Government financing that has forced interest rates down to a point that interest on endowments produces very little; so that the institutions, medical schools, and others, that were existing on endowments not only are faced with higher costs, but lower returns on their endowments.

Senator MURRAY. What you mean is that the Government has adopted a policy of not permitting unlimited earning capacity in this country, that they must return some of it in the form of taxes; since that system has gone into effect, there have been fewer contributions from the people in the high-income brackets?

Dr. HAWLEY. Not necessarily in the high income, but contributions from people, let's say, in the moderate-income brackets. It was not the few millionaires in this country who supported voluntarily the hospitals. It was a large number of people in what you might call moderate-income groups that made annual contributions that paid the deficits of hospitals in this country. The great bulk of the money came from people of moderate incomes.

Senator MURRAY. But now you say that source has dried up as a result of the policies of the Government?

Dr. HAWLEY. Not entirely. I said I thought the Government contributed to it. I would not say that it was responsible entirely; no.

Senator MURRAY. You are not opposed to the program in this bill for subsidizing medical education?

Dr. HAWLEY. As a citizen, yes, I am. But I see no other way out, if we are going to continue medical education. I am opposed to the principle very much; yes, sir.

Senator MURRAY. It does seem to me there is no other way out either; if there are no voluntary contributions made to these educational institutions to enable them to expand or to provide new medical schools, the only thing that can be done would be for the Government to step in.

Dr. HAWLEY. I agree with that. I would not disagree with that.

Senator MURRAY. You say in your statement here:

> The need is for more medical schools, yet this provision of the bill is a bribe offered to struggling schools further to sacrific quality for quantity.

I do not understand that there is anything in the provisions of this bill that would justify a statement that this is a bribe to sacrifice quality for quantity, because the bill throughout seeks to maintain the very highest quality of medical education and medical care.

Dr. HAWLEY. It is, I think, generally accepted in the field of medical education that the schools of this country are today graduating as many physicians as they possibly can with the facilities at hand and still do a job; and that when you get classes of medical students over 100—and many medical educators would put that much lower; they would put 80 as the proper limit of the senior class—and when you try to have these huge classes, you are going to sacrifice quality for quantity.

I would not argue the point of more medical schools. But when you make a differentiation and pay $300 per student for the ones that they are now educating, and then offer them $1,700 for each student that they will take over and above that, I consider that a considerable inducement to expand their facilities above the point that they can do a good job.

Senator PEPPER. But, doctor, would it not be appropriate to let them be the judges of whether they think they can do a good job or not, and for us not to pass ex cathedra judgment on them and condemn them here in the Capital?

Dr. HAWLEY. Of course, now we are getting into a realm of opinion. That opinion I express is not my own, but after consultation, and talking with many medical educators; they are very concerned about this.

Senator PEPPER. We are not proposing this measure to make it mandatory upon anybody to enlarge their facilities.

Dr. HAWLEY. That is true.

Senator PEPPER. We simply say that if they can enlarge their facilities, the Government would give them this help to do so and one figure for the new facilities contemplated construction costs and all that sort of thing as against operating expenses in respect to existing establishments.

Would you not be rather severe to condemn as dry pickings every school that would take advantage of this law, if it were a law?

Dr. HAWLEY. As a generality like that, I certainly would. But I have in mind several schools that are in a terrific position, and I do not know whether they can resist that temptation.

I would consider it certainly removing all effort or all implications of a bribe if a flat subsidy were given for each medical student instead of the added inducement to take more.

Senator PEPPER. I think it would be proper if we tell you that this committee contemplates inviting the outstanding medical and educational authorities in the country, I mean the medical school leaders in the country, here to advise us about what form this Government assistance should take.

In fact, I think Senator Taft's bill proposes to give aid to at least existing medical schools in their operation; and I think everybody who has discussed this matter has agreed that we do need to turn out more doctors.

We are simply thinking about how we can help in some instances, because it might be a matter of means. If you can suggest some better way that will not cost the taxpayers any money that we could adopt, that would turn out an adequate number of doctors of high quality, we would be very glad to have your suggestions.

Dr. HAWLEY. I wish I could suggest some way that would not cost the taxpayers. I do think that an equalization of the subsidy on education to take away the inducement to increase the number of students in existing schools would be a great help.

Of course, I do not presume to speak for the medical schools of this country. I am giving only my own opinion; but I will be very much interested to read the testimony given by medical educators upon this particular report.

Senator MURRAY. You think they would be better qualified to give us sound judgment?

Dr. HAWLEY. Very much.

Senator MURRAY. This problem of medical education is acute now; is it not?

Dr. HAWLEY. Very acute.

Senator MURRAY. And it has been developing over a long period of years. I remember at the commencing of the war what great difficulty the armed forces were having in getting medical men and dentists, and it was a terrific problem.

Yet I did not notice that the American medical profession interested itself very much in that problem and did not seek to work out a program for us that might prevent this situation which is before us today.

It is acknowledged now that there is not enough medical men in the country, not enough dentists, to provide proper care for the American people. So it has become extremely acute.

Do you not think that was a mistake on the part of the medical profession not to have taken hold of this thing long ago and not just stand back and provide funds for opposing anything that is proposed in Congress? This fight has been going on now for the last 10 years approximately, and it does seem to me that somebody has to do something about it, and we in the Congress proposed legislation of this kind.

At first all we got was abuse. Now they are coming to recognize that there is a problem in this country and that some way should be found, in using your own statement here, you say you do not condemn compulsory insurance completely. You think it is something that might have to come.

Dr. Hawley. That is right. I agree with that. I will say that. It might have to come. I think it is very premature at this time.

I will not evade your first question. I think that the position taken publicly by medicine in the past has frequently been wrong.

Senator Murray. You do not approve, then, of this widespread abuse of those of us who have sponsored legislation of this kind?

Dr. Hawley. No, sir.

Senator Murray. You do not believe they had any right, for instance, to call me a Red and that should be run out of the Senate in the last election?

Dr. Hawley. Senator, you know I have been with you on unofficial occasions, and I have never expressed in your presence or out of it any such opinion.

Senator Murray. I appreciate that, doctor. At least, we have always been very friendly. You have testified before us before, and I have always had a high appreciation of you. I have today. I think you have been very candid.

Dr. Hawley. I could not have been less forceful and really have expressed my opinion. But I assure you that there is nothing personal in that testimony.

Senator Murray. But it seems to me, though, you have gone pretty strong here in condemning this program that we are proposing here, and I do not think that you have the full facts to justify the scathing denunciation that you have given to it.

Dr. Hawley. I hope it is so regarded by lots of other people, Senator. But I admit very frankly I do not have all the facts, and I do not think the other side has all the facts.

The most important thing that I urge is that we get the facts.

Senator Murray. Even the great leaders of the American medical profession have been one-sided and vacillating in it. At one time they were opposed to voluntary insurance and said that that was absolutely impossible, and if we were going to have any kind of a system, it should be compulsory. They were opposed to a good many programs that have since been put into operation and today are working very satisfactory, like group medical care and other programs of that kind.

Dr. Hawley. That is all very true, sir.

Senator Murray. So it seems to me that it has been unfair for them to indulge in such widespread effort to discredit this program without having adequate facts upon which to base their denunciations.

When I came into this situation here in the Congress I thought that I was going to get along fine with the medical profession. I thought that they would come in and sit down with us and try to work out a program.

But instead of doing that, they just began to collect funds to see what they could do in regard to discrediting the whole thing.

I think that has been a very serious mistake. If we had started 10 years ago to work together on this thing, we would have had it all over before now. But I want to say that I am very satisfied with your testimony today insofar as you admit that there is a need for this program and that we are not so wicked as some of the literature that is published by the opposition would seem to indicate.

Dr. HAWLEY. Senator, would you not extend your approval to another paragraph, where I said that many of the arguments against are not so convincing?

Senator MURRAY. That is right, you did say that; very good.

Any questions, Senator Pepper?

Senator PEPPER. General, may I call your attention to page 5 of your statement where you say:

> It does not require much experience in the field of health insurance to realize that the benefits outlined in section 701 of this bill, classes of personal health services, will cost at least three or four times the amounts provided in the most liberal of the voluntary nonprofit prepayment plans. Since there can be no protection erected against abuse of the privilege of unlimited home and office calls, efforts to offer such services by voluntary insurance have proved to be more costly than the average family cares to share. This is the present experience in England * * *.

Now, I want to ask you about the completeness and comprehensiveness of the coverage under 1679, with the coverage under Blue Cross and Blue Shield, and a comparison of the figures as they are manifested in the cost.

Dr. HAWLEY. Well, when you talk about Blue Cross and Blue Shield——

Senator PEPPER. You are speaking for those two?

Dr. HAWLEY. Yes. At the present moment you are talking about a wide variety of plans. There is a very definite movement among the voluntary plans to extend their coverage as rapidly, and as far, as possible. That statement was based upon what I consider some of the more comprehensive plans, and we can take as an example one which has been quoted here and which I happen to be a little more familiar with.

Take the Michigan plan. Under the Michigan plan, it costs a family between $80 and $85 a year for the protection that they offer. That is a very comprehensive protection against the cost of hospitalized illness.

Senator PEPPER. That is just hospital coverage?

Dr. HAWLEY. No, and medical care in hospital, cost of hospitalized illness. There are a few additional benefits such as——

Senator PEPPER. Does that include surgery?

Dr. HAWLEY. Yes.

Senator PEPPER. That includes maternity care?

Dr. HAWLEY. Maternity, medicine, and it also includes treatment in the accident room of hospitals outside; and it includes the setting of a broken arm in a doctor's office or something like that, to save any necessity for going to the hospital.

Now, the statement that has been made frequently—it was made by Mr. Cruikshank this morning—that even the best of the nonprofit plans does not pay more than one-third of the cost of medical care of a family; so you can start from that point and multiply the cost of that plan by three.

Let's say it costs $85 a year. That is $255 a year. Most of our contracts run about 2.4 to 2.67 beneficiaries per contract. But you would have to add something to the cost of a family contract in a nonprofit plan because most of the nonprofit plans load the single subscriber's charge a little bit, and take that amount off of the family contract, which reduces the cost to the family.

Now, if your families run that many subscribers per contract, right there you come back with a figure of right around $100 per beneficiary per year, which is three times the benefits now provided by the Michigan plan.

Senator PEPPER. I have before me the voluntary prepayment medical care plans, 1948, a document Mr. Cruikshank referred to this morning, by the counsel on medical service of the American Medical Association, and it says it is State-wide, a combination service and cash indemnity, and this is the income limits. This is supposed to be the subscription of the Michigan Medical Service. That is what you are talking about, is it not?

Dr. HAWLEY. Yes. But if I might interrupt there, it was implied this morning in that testimony that there were income limits to Blue Cross as well as Blue Shield. There are no income limits on Blue Cross; and the service of which I spoke in Michigan was a combination both of Michigan Medical Service and Michigan Hospital Service, which is the Blue Cross plan, and together cost that amount.

Senator PEPPER. Page 34 of this document says:

> Income limits does not limit enrollment, but where incomes are in excess of the following, the specified benefits are accredited to total charges for services rendered: Subscriber, single, $2,000; family, $2,500.

That suggests to me that the benefits conferred or granted under the plan for those above those income brackets are simply credits against the total charges.

Dr. HAWLEY. That is true. But that is not the whole truth. First, we have got to remember that the fee schedule paid with income limits like that is very, very low. It is much lower than the prices charged, and the fees paid are much lower than would be paid for families of incomes of 4 or 5 or 6 thousand dollars.

Now, there are other considerations in Michigan, if it has not already gone through in the last month, a movement to raise that income limit to $4,000 per family and at the same time to increase the fees paid.

When you pay only $75 for the surgical fees for a series of abdominal operations, you are not paying a very big fee. And as long as you can have that fee schedule, you can sell that service very cheaply to low income.

Senator PEPPER. I am glad you mentioned that. The Blue Cross and the Blue Shield have some schedule of fees that they pay doctors and hospitals for certain services rendered, do they not?

Dr. HAWLEY. The Blue Shield has a schedule of fees that they pay doctors. Blue Cross has no schedule of fees. It has a contract with each hospital, each participating hospital, for the furnishing of services.

Senator PEPPER. Is that for the same thing that would occur under the national health insurance program, that is, that there would be a fee schedule agreed upon with the doctors that care to come into the plan, and there would be a contract with hospitals that cared to come into the plan? And is not that the only way the doctor would be affected, just as it is the only way that he is affected by your plan?

Dr. HAWLEY. No, sir; there are two fundamental differences there. Right now the fees are set by the people who furnish the service; and in S. 1679, in case of any disagreement, the fees are going to be set by the Government. That is No. 1.

Senator PEPPER. Would you just stop there just a minute? You say the fees are going to be set by the Government?

Dr. HAWLEY. Yes.

Senator PEPPER. Is there anything in this bill to make a hospital or a doctor come into the plan?

Dr. HAWLEY. No, sir.

Senator PEPPER. How are the fees going to be set by the Government then? If he does not like the fee the Government is going to pay, he does not come in just exactly the same way as in the Blue Cross-Blue Shield; if they do not want to enter into a contract with the Blue Cross, the hospital does not, does it? And if a doctor does not want to participate in the Blue Shield, they do not sign up; do they? Is that not the same principle?

Dr. HAWLEY. I do not know that it is the same principle. But, of course, everyone knows, and you know why the doctors of Britain came into the thing. It was come in or starve.

Senator PEPPER. It was what?

Dr. HAWLEY. Come in or starve. I mean, if you consider that a choice, then I say the doctor has a choice of staying out and a hospital has a choice of staying out.

Senator PEPPER. Doctor, let's see whether it would of necessity entail starvation upon a hospital or a doctor that did not come in. The hospitals are being supported at the present time generally by patients and charity. Is there anything in the national health insurance bill that would prevent a hospital staying out of the plan and continuing to operate as they do now?

Dr. HAWLEY. Yes; because a large part of its potential customers are taken out by the national insurance plan.

Senator PEPPER. But by hypothesis of a great many people there will be a great number of the people that will not want to go under this plan. They will want to go on their own, make their own contract with the doctor, go to the hospital of their choice, keep the old relationships that they had before.

Whereas, in England, the Government, as I understand it, has taken over all the hospitals. You do not see anything in the National Health Act that provides that the Government is going to take over these hospitals, even the ones that the Government helped build; do you?

Dr. HAWLEY. Do you think, sir, that many people who have their pay rolls tapped are going to go to a nonparticipating physician and to hospitals that are not participating in the plan?

Senator PEPPER. The Catholics are taxed to support the public schools, and yet a lot of them send their children to religious schools. Private citizens are taxed to support public schools, and yet a lot of them send their children to private schools of even a nondenominational character, simply because they choose to do so.

They do not want to send their children to the public schools, though they are paying taxes to support the public schools. They just do not want to do it. There is no reason today in America you have to send your child to a public school.

Dr. HAWLEY. I am wondering whether most of the Catholics would rather stop sending their children to parochial schools or to stop paying taxes to support compulsory education. And you have the other element in that case, which I think is not strictly analogous, and that is that the reason that they are sending their children to parochial schools is not so much a distinction between the two types of the grades of education as it is a religious——

Senator PEPPER. It is a matter of personal preference. They have the right to exercise that personal preference.

Dr. HAWLEY. I doubt that a religious conviction is a personal preference.

Senator PEPPER. What about people who send their children to private schools? Are there not a lot of private schools all over the country?

Dr. HAWLEY. Compared to public education, it is negligible.

Senator PEPPER. Compared to public education, I suppose there are not as many children in the parochial schools. Is there not some analogy in that it might well have been left to the people who could send their children to school to do so, and no doubt there was a time when that custom prevailed. It eventually became apparent that the public interest demanded that everybody help to educate all the children of the country, whether he was a bachelor, widower, or whether he had any children or not, whether you believed in it, whether you wanted to send your children to a religious school or a private school. That became the settled public policy of the country, because experience indicated to the majority that it was in the public interest to do so.

It may well be that the analogy applies to health. It may be a lot of people think there is nothing more important to the public interest than the health of this country, and that the only way you can see to it that everybody has an opportunity to get medical and hospital care, get the drugs they need—this morning Senator Lodge was in here with a bill, a very interesting bill, proposing that we give the necessary drugs of a rare and costly character to the people that need them.

It may be, he concluded, the only way we will ever be able to do that for everybody, although everybody may not want to take advantage of it—a lot of people will have to stay out in a ward. They will want a private room, but the national health insurance does not guarantee you a private room in a hospital unless the doctor said you need a private room for your care.

But a lot of patients would not want to stay out in a ward. They would insist upon a private room and a nurse every 8 hours, even though maybe they would not be given that without the doctor's recommendation under national health insurance.

But I say it may well be that public policy requires that we do something comparable for the public health, what we have done for public education, make it compulsory to go to a school, bring the school within the reach of the child, whether it be rich or poor.

Dr. HAWLEY. May I comment?

Senator PEPPER. Yes, sir; I wish you would.

Dr. HAWLEY. In making compulsory public education, Senator, we all know that we did it with a considerable sacrifice of quality. Now, it is not——

Senator PEPPER. You would not change it, would you? You would not give better quality for the few, even if the general quality is below the quality that the favored few might have?

Dr. HAWLEY. Not in education, no. But a poor quality of education does not have nearly the impact upon the lives of people that a poor quality of medical care has, and I do not think that the analogy is accurate, that you can argue from A to B on the question of education and medical care.

Senator PEPPER. That reminds me of the old adage that "A little education is a dangerous thing."

Dr. HAWLEY. I think our public programs prove that on more than one occasion, sir.

Senator PEPPER. I doubt if you would want to advocate publicly changing it, would you, general?

Dr. HAWLEY. No; I am not arguing about changing it, but I say I do not believe it is strictly comparable.

Senator PEPPER. We were talking about the relative cost of these proposals. How many people are covered under Blue Cross now?

Dr. HAWLEY. Thirty-four million, of which 31,500,000 are in the United States and its possessions, and about 2,500,000 in Canada.

Senator PEPPER. You say 34,000,000?

Dr. HAWLEY. Yes, sir.

Senator PEPPER. That is people covered altogether?

Dr. HAWLEY. That is beneficiaries.

Senator PEPPER. That is under Blue Cross and Blue Shield?

Dr. HAWLEY. No; that is under Blue Cross.

Senator PEPPER. How many under Blue Shield?

Dr. HAWLEY. Blue Shield has passed the 11,000,000 mark. The Blue Shield is much younger than Blue Cross. I put that in parenthetically.

Senator PEPPER. General, have you had a chance to study the bills sponsored by Senator Taft and his associates, and if so, would you care to make any comment about that approach to the problem?

You are not advocating, as I understand it, any subsidy of any sort?

Dr. HAWLEY. Oh, no, sir.

Senator PEPPER. You advocate the straight-out voluntary——

Dr. HAWLEY. That is not true. I think we will have to subsidize diagnostic facilities. I think that very much, and I think that is a very great need. I think we will be forced into a position of subsidizing medical education, as bitter a pill as that is to swallow personally.

Yes, I think we will always have to pay for the medical care of the people who cannot afford to pay.

Senator PEPPER. Those who are really indigent?

Dr. HAWLEY. That is right. Now, we may have to, and should have to, make it possible for—I do not know whether under a good voluntary insurance there are any such classes of medically indigent. Ninety-eight percent of our people are medically indigent in one way or another, if you take in the long duration care of medical cases such as in tuberculosis. That is a term which is pretty hard to define.

Senator PEPPER. Now, Senator Hill and some associates have advocated a bill, which, as I understand it, contemplates that the Government with the States will supply the deficiency of the premium.

Dr. HAWLEY. No, sir. May I explain that? No, sir; that was another incorrect statement made by someone this morning—that Senator Hill's bill subsidizes the voluntary plans. Senator Hill's bill does not add a penny to the income of any voluntary plan. It merely uses the mechanism already established by the voluntary plans for the care of the indigent, whereby the indigent will receive membership cards in voluntary plans, and the voluntary plans will pay the hospital and the doctor, but be reimbursed from public assistance funds.

Senator PEPPER. Federal and State assistance will simply pay the premiums to insurance——

Dr. HAWLEY. No; there are no premiums paid. The voluntary plans will not insure them. It is merely the payment of costs of their care through the mechanism of the voluntary plans which removes them from——

Senator PEPPER. What voluntary plans?

Dr. HAWLEY. Any existing or any to be created.

Senator PEPPER. But the Blue Cross will not take them——

Dr. HAWLEY. Yes; they will take them.

Senator PEPPER. That is what I said a minute ago; they propose to pay the premiums.

Dr. HAWLEY. No; the bill does not propose to pay the premiums.

Senator PEPPER. In a voluntary organization?

Dr. HAWLEY. No, sir; not of the indigent, no, sir. Senator Hill's bill does not propose that.

Senator PEPPER. How would they get them the care? I thought you said they wanted to enroll them in a voluntary system.

Dr. HAWLEY. No, sir; they do not enroll them as paying subscribers under that bill. They get from the voluntary plan a membership card, but they do not pay anything for it.

Let's just take a typical case. This family is unable to pay. The welfare agency or whatever the public assistance agency is, says to the Blue Cross, "We want a card for this family."

Blue Cross issues that family a card. No money changes hands.

Senator PEPPER. Does not anybody pay the Blue Cross?

Dr. HAWLEY. Not until the family needs medical care.

Senator PEPPER. Then who pays?

Dr. HAWLEY. Then the public assistance pays Blue Cross for the cost of that medical care and for——

Senator PEPPER. So it is not voluntary insurance at all. They do not pay a premium regularly then. It is not prepaid.

Dr. HAWLEY. That is right. It is not insurance of the indigent; no, sir.

Senator PEPPER. Very well. You cleared that up. That is in respect, then, substantially the same as the Taft bill.

Dr. HAWLEY. It is a means of paying directly for the care of the indigent.

Senator MURRAY. Confined entirely to the indigent?

Dr. HAWLEY. Yes, sir.

Senator MURRAY. And it does not help those people who are not exactly indigent, but who have difficulty in meeting the payments of voluntary insurance?

Dr. HAWLEY. That is true, except the provision which says that during the periods of unemployment, anyone carrying any type of voluntary insurance, the premiums will be paid from the public funds during the period of unemployment.

Senator PEPPER. They are unemployed. They are not in the gainfully employed class?

Dr. HAWLEY. That is right. So it does not force them to drop the protection which they have carried while employed.

Senator PEPPER. Out of your experience in this field, is it not the principle problem to work out some way to bring adequate medical and hospital care within the reach of the people who are above the unfortunates of our citizens whom we all agree are indigent and have to have public health?

Is not the real problem to work out some way by which they will be able to pay for the medical care that they require?

Dr. HAWLEY. That is a problem, sir. May I ask how many of that type of people you estimate that there are in this country?

Seriously, our own conviction in this voluntary field is that practically every self-supporting person can afford to carry voluntary insurance.

Senator PEPPER. Doctor, they maybe can afford to carry voluntary insurance, if they were wise enough to take it out. Maybe a lot of people could afford to carry life insurance that never could feel that they could get up the premiums for that matter.

I guess that is the reason we put old-age and survivors insurance into effect in 1935 and never have changed it.

But your plan contemplates the voluntary premiums, voluntarily paid by self-enrolled people. Now, I never have been quite clear as to how far above that class we were talking about awhile ago, the admittedly indigent class to which Senator Taft's bill proposes to go, just how he proposes to get that.

I have heard the Senator a number of times refer to an income level, maybe $2,500; not a firm figure, but just an illustrative one. He thought you could fix the matter of indigency on the basis of an income level.

Then when you get above that in what we call the great white-collar class, then the only way I can see that such a bill as that would operate would be simply to go examine the ability of these folks to pay by some sort of an inquiry and then give them as much as was deemed necessary to make up the lag between their ability to pay and the cost of the services that they got.

One of the virtues of the national health-insurance bill is that it certainly simplifies the question as to ability to pay because it is a pay-roll deduction or tax required by the Government from the citizen. It certainly has the advantage of simplicity, and in respect to the payroll of the employee, he is already having a deduction made from his pay roll, and the further deduction would run through the same accounting procedure as the previous deduction.

Then it certainly would have a universality which the voluntary plan cannot hope to achieve any time in the near future, can it? You do not hope to achieve anything like the universality of operation or coverage which the national health-insurance law would achieve, should it be enacted into law in the near future?

Dr. **Hawley**. We certainly do, sir. We certainly do. How many people are covered by old-age and survivors insurance now in this country?

Senator **Pepper**. I do not know the number. Maybe some of these folks around here know.

Dr. **Hawley**. Around 60,000,000? I think Blue Cross will pass 60,000,000 in the next 3 years.

Senator **Pepper**. Do you think your rate of increase will continue that fast?

Dr. **Hawley**. It is growing; the rate is growing.

Senator **Pepper**. It undoubtedly is growing, General, and it made a very valuable contribution to the field. It has grown because of the realization of people that there has got to be some kind of a prepaid medical care system in effect in this country.

Do you not think that that is what is responsible for it?

Dr. **Hawley**. That is right.

Senator **Pepper**. Now, the question is: Starting out with that assumption, which is our assumption also, will enough people join up voluntarily? Will you be able to keep the rate down to the lesser number who do join and keep them in once they have joined so as to achieve the public good that would be achieved by everybody by force of law? I mean, the major part of the population having to join, having to pay the tax, having to get in and having to stay in, because they were required by law to stay in.

Is that not essential to the balance of interests that are involved in the matter?

Dr. **Hawley**. If that were your objective, sir, why not do what has been done in the other fields of insurance? Certain States, I think one is Massachusetts, will not let you drive an automobile unless you carry insurance, but it does not prescribe it and it is not Government insurance.

There are many States that have workmen's compensation which merely states that the employer must carry insurance. But he has a free choice of what kind of insurance that he carries.

Senator **Pepper**. That is entirely a possible approach, general, and it is what we had in the back of our heads when we put that provision in there. that these voluntary plans might be used. And in spite of your statement here, I got the intimation——

Dr. **Hawley**. I do not think they could exist under that bill, sir.

Senator **Pepper**. If you could suggest any language that you think would require the making of proper use as one of the instruments of this public general policy of the voluntary associations, we would certainly be glad to have it. We realize that the Government just cannot go around ordering people to join up private organizations. We can require them to become members of a public authority, as it were, to enroll themselves in a compulsory national insurance program.

But you get into a little more complicated problem when you say they must join up in a private organization. I cannot speak for everybody, but I feel as if I have talked to Senator Murray enough to believe it is his intention, as it is mine, to make the fullest possible use under this bill of the voluntary insurance organizations, and any suggestion you will give which will help clarify what in your opinion is an unclear portion of this bill, we would be very glad to have it because it is the intention of the authors of this bill to use these voluntary associations in any proper way that they may be used.

Dr. HAWLEY. That might take a great deal of time at this moment.

Senator PEPPER. We would be glad to have you submit it. Would that not be all right, Mr. Chairman?

Senator MURRAY. Yes.

Senator PEPPER. We would be glad to have you submit it later. The main thing we are trying to achieve, General is the widest possible coverage and to keep the people covered, because we know that when they had the Farm Security Administration program under way, we got the statistics on how the people participated, and the ones that needed it worst were the ones who fell out first.

When illness struck, there they were, a charge upon the community, nobody to look after them, simply because they fell out.

I do not know what your experience is about how your members fall out. What is your turn-over?

Dr. HAWLEY. That varies with different plans. Unless a person removes himself from the area of the plan or from a group which he has joined, the losses are very, very low. There is some loss when a person moves from an insured group to an uninsured.

Senator PEPPER. I am not talking about moving so much as those who may drop out.

Dr. HAWLEY. Practically none. Of course, we lose occasionally to competitors, but an insured group to drop its insurance is an unheard of thing.

Senator PEPPER. I am talking about individuals. You enroll individuals, do you not?

Dr. HAWLEY. It is a very rare thing in a group, an individual in a group.

Senator PEPPER. You largely just enroll groups?

Dr. HAWLEY. No, most of our enrollment is in groups, because in that way we reduce the costs of acquisition. But we are now, having gotten many, many large groups, going after nongroup enrollment.

Senator PEPPER. Do any of those groups pay through voluntary deductions of their pay roll?

Dr. HAWLEY. A great number. In the beginning of Blue Cross, that was almost the only way. There was no employer contribution. Now, a large number of Blue Cross—we are looking to get some figures on that, the United States over, what percentage of employers contribute and what not. But a large number of the employers contribute half.

Now that health benefits have become an item for labor-management negotiations, there are an increasing number of groups in which the employer pays the full premium.

We have the evolution of this whole subject from the case where the patient paid his own bill, if he were able to pay it—otherwise he got charity or he did not get any care.

Then we have seen industrial insurance grow up. the extension of commercial insurance. Then we have seen the various voluntary plans that have grown up and expanded.

Finally, the doctors, seeing that something had to be done in this field, started to work out their own plans. The whole structure of this thing has been an evolutionary one getting away from the fee for service by the individual or the acceptance of charity by the individual into a prepaid plan of some sort.

Whether or not we should go on further to the objective that we declare, or whether we should stop short of that, is the subject we are debating right here now.

Senator PEPPER. If you can give us anything on the voluntary thing, we would be glad to have it.

Dr. HAWLEY. I would not leave you with the impression that I feel that there are no deficiencies in the voluntary system. There are many deficiencies. We are working very hard——

Senator PEPPER. We do not want you to understand that we claim there are no deficiencies in the compulsory system. There are a great many of them. Except we do claim once having gotten over the hurdle of inability to pay, the next problem we will tackle is, as you say, to keep up the quality of medical care and to keep too much red tape out of it, too much corruption and politics, and all the other vices that creep in.

Nobody claims it is not full of bugs.

Senator MURRAY. Are your plans capable of taking over any of these large groups in industry, where the industry insures the workers on medical care?

Dr. HAWLEY. Yes. We would be in a very much better position 2 months from now.

Senator MURRAY. You are taking over a lot of those groups from industry?

Dr. HAWLEY. Yes.

Senator MURRAY. Take, for instance, in the mining industry in the West; they pay something like $1.50 to $2 a month into a fund, deducted, I believe, from their wages; and that gives them medical care.

Are you able to take over those groups on that basis?

Dr. HAWLEY. If those are a part of Mr. Lewis' organization, the answer is "No." They are carrying their own costs not on an insurance basis, but payment out-of-pocket. We would like to convince the United Mine Workers committee or organization which is handling that insurance we would save them a great deal of money on that.

In other industries, yes; and the field is now opening up. We are hopeful of getting many large industries comparable and even larger than the United Mine Workers.

Senator MURRAY. Are you considering taking over, for instance, the Kaiser programs of medical care?

Dr. HAWLEY. No, sir.

Senator MURRAY. Why not?

Dr. HAWLEY. Senator, you do not want me to talk on what I think about that general type of medical care, because all experiments in medical care in the field of paid staffs have never produced the quality of medical care that you would want if you were thoroughly familiar with it, or that I would want.

That is a bad way of producing medical care, to hire a bunch of doctors and open a hospital.

Senator MURRAY. Mr. Kaiser disputes you on that.

Dr. Hawley Well, I expect some other people——

Senator Murray. And he has some men in his organization who are medical men claiming they are giving the very finest kind of medical care.

Dr. Hawley. Yes, I know. I am not having any part of it when I get sick. It is not in my books. I do not mean to disparage it. I am sure there are some good doctors with that organization.

Senator Murray. In order to make your plans operate successfully, it seems to me that you have got to take in practically the full population. If you only have a percentage of the people of the country in your plans, the plans then are more expensive to operate. You cannot get any young people who are starting out. They will not voluntarily join.

You do not take in the older people, because they are excessive risks.

Dr. Hawley. We do not throw them out, sir. There is a limit to new enrollment in most plans of 65, although that is not true throughout the Blue Cross field.

Senator Murray. Millions of people in the country now are 70 years of age.

Dr. Hawley. That is true, and we cannot offer this for those people for the remainder of their lives, it is perfectly true. But we have thousands of people in Blue Cross who are over 70 years of age.

Senator Murray. You are not getting in the young folks, though.

Dr. Hawley. I think we are. If you would look at some of the maternity bills that these plans have to pay, we are getting in plenty of young folks. That is what costs us.

Senator Murray. I mean to say those young people that are not married yet, that are just out of school. There are millions of them.

Dr. Hawley. Most Blue Cross plans take care of children of families until they reach 19 years of age.

Senator Murray. After the age of 19, they go for some considerable time——

Dr. Hawley. Then they become individual members.

Senator Murray. Before they consider matrimony, they have to find a job, and that is going to be a difficult thing. Right now the unemployment is developing in various parts of the country, and millions of young folks are considering entering into the employment field.

How are they going to take a membership in your organization?

Dr. Hawley. They can take it as individual members, very, very cheaply. If they have been family beneficiaries during their childhood, when they reach that age, all they have to do is to notify the plan and become an individual subscriber.

Now, somebody has to pay for their medical care and perhaps it would be much cheaper for the father, who has to support them through college, if he paid for their medical care by taking out an individual subscription for them. It is very cheap for individuals.

Senator Murray. That concludes my examination.

Senator Donnell. Doctor, it is so late here, I hesitate to impose an examination upon you, and I shall not do so.

I would like to ask a few questions of you if you are still able to answer the questions. Doctor, I noted with much interest in your statement your comment right at the outset on what are obviously very superlative terms in this bill. You said the statement that the vast majority of our people are unable to meet the shattering costs of serious illness is contrary to well-known facts. You commented on the shortage of physicians and hospitals, the statement that the shortage of physicians and hospitals is critical and you say that is a gross exaggeration.

Do you have a copy of the bill there, Doctor?

Dr. HAWLEY. Yes, I do.

Senator DONNELL. I think your comment is decidedly important there, and right in point. If you will turn to page 6 of the bill, I think you will observe there that, in effect, what is being done here by the use of these highly superlative exaggerated terms is to make in effect a finding of fact, a legislative finding of fact.

Dr. HAWLEY. I so interpret it.

Senator DONNELL. Yes, sir, and you do not mind just running down with me, I will not have you read the whole page; but it speaks here about certain situations which have resulted in the following conditions:

One—just notice this highly superlative language, some of which you commented on, some of which you have not—there are seven of these categories. We will just take them one at a time. One, the inability of the vast majority of our people to meet the shattering cost, and so forth.

You have already disposed of that. You say that that is contrary to well-known facts. You still believe that to be true, do you Doctor, that it is contrary?

Dr. HAWLEY. I believe that to be contrary to the facts.

Senator MURRAY. But you admitted the American Medical Association has issued the statement that people earning less than $5,000 a year are unable to meet the costs of medical care.

Dr. HAWLEY. I admitted the existence of that statement, yes, sir.

Senator MURRAY. Is that not a vast majority of our people? That is 80 percent?

Dr. HAWLEY. It would be, if it were true.

Senator DONNELL. The Doctor is testifying himself here. You are not here just as a rubber stamp for somebody else, are you?

Dr. HAWLEY. Blue Cross and Blue Shield. I am not testifying for the American Medical Association.

Senator DONNELL. You are coming here to give us what you think are the facts?

Dr. HAWLEY. Yes, sir.

Senator DONNELL. Certainly. So, in No. 1 here there is this language, about the inability of the vast majority of our millions of people to meet the shattering cost, the vast majority. You think that is not a conservative statement, to say the least? I am right in that, am I not?

Dr. HAWLEY. It is not an understatement.

Senator DONNELL. You think it is an overstatement?

Dr. HAWLEY. Yes, sir.

Senator DONNELL. The second one, the inability of most of our people—that, of course, would be over 50 percent of our people—to benefit from modern preventive medicine.

Do you have any comment to make on that language?

Dr. HAWLEY. Yes.

Senator DONNELL. What is your comment on that?

Dr. HAWLEY. Ninety percent, maybe 95 percent of preventive medicine is in the field of public health. It has been grossly exaggerated how much you can prevent by having a patient run to a doctor for a going over.

The Army has had annual physical examinations for 25 years, and I do not know that they have ever prevented very much by doing it. You discover some things, but the great contributions of preventive medicine in this country have been in the field of public health, of water and sewage and the control of communicable disease; and I do not believe that most of our people do not benefit from that. I think the actual mortality figures show that they benefit greatly from that.

Senator DONNELL. So that is the second one of these seven categories that you do not agree with. The third one you have already commented on, a critical shortage of physicians, and so forth. You say in your statement, and I ask you if I understand it correctly, you say that the shortage of physicians is critical is a gross exaggeration.

You believe that?

Dr. HAWLEY. I think it is. I do not think it is critical. I think we should have more physicians. I want to make that very clear. I do not think we need more physicians to take care of sickness in people. But I think more physicians would divert physicians from the actual practice to some of these other fields in which I think they are needed.

Senator DONNELL. Then we pass on to the fourth of these seven categories in which these superlative expressions appear in what I consider findings of fact.

Senator MURRAY. Before you pass on there, I would like to ask him if it is not a fact that the Army conceded that the scarcity of doctors was a critical situation?

Dr. HAWLEY. That is true; yes, sir. I sweated through that for the last 6 months on the Cooper committee, but I do not think that is because there are too few in the country.

Senator DONNELL. Now, the fourth one of these seven categories is the alleged critcal shortage of hospitals. You have already commented on that. You said that is a gross exaggeration.

Dr. HAWLEY. I will concede that there is a critical shortage of diagnostic clinics in the country.

Senator DONNELL. But as to hospitals, you think that is a gross exaggeration?

Dr. HAWLEY. I do; yes, sir.

Senator MURRAY. You think it is unnecessary to expand our hospital facilities?

Dr. HAWLEY. I would rather the hospital people would testify to that, Senator. I am in the prepayment field here, and that is argued back and forth. I think you have some testimony tomorrow from the American Hospital Association on that.

Senator DONNELL. Doctor, I did not intend to unduly hold you here. Of course, these interruptions—it is all right for the Senator to interrupt, but I do not want to have his time charged to me.

Now, the fifth one of these seven categories, wholly inadequate provisions for the health needs of our farm families and agricultural workers. You have commented on that, and you say in your statement:

> Neither is it true that the provision for the health needs of farm families is wholly inadequate.

That is your feeling on the matter, is it?

Dr. HAWLEY. I come from an intensely agricultural region in southern Indiana. I practiced medicine there one time. I go back there very frequently. I should say that those farm people have an excellent quality of medical care. There is no hospital within 20 miles of this little town, but there are ambulances and they get them to the hospitals in emergencies, and no one has to wait.

I should say that the medical care of people in that area, and as I visit other farmers—sure, there are agricultural areas where there is a scarcity of doctors. Take central Pennsylvania up here where the Pennsylvania Dutch are, and large agricultural areas in this country have a pretty good quality of medical care.

So I do not think that the provision for the health needs of farm families is wholly inadequate.

Senator DONNELL. Now, doctor, dropping down to the next one, the sixth out of these seven categories, the language there is a very modest type of language. It says:

> The development of research on a scale appallingly inadequate in relation to the dreadful cost of disease * * *.

I do not mean by my questions in any sense to minimize the ravages of disease or the importance of research. Do you think if you were writing that finding of fact there that you would use those terms "appallingly inadequate," particularly that term in reference to the scale of the development of research at the present time?

Dr. HAWLEY. People in the research field, I think, are almost unanimous in the fact that the deficiencies, if any, in medical research are not due to lack of financing, but there are just about so many people that you can produce in a year, no matter if we opened up everything, who have the peculiar ability to do research.

I do not know any way that you could throw money down a drain faster than to toss it out for widespread research by people who are not competent to do research. I think when you look back over the contributions in the medical research of the past 25 years, they have been rather amazing.

Senator DONNELL. So you do not share the use of any such language——

Dr. HAWLEY. Certainly there is an awful lot to be found out that is not known. But I think the progress that is being made is rather amazing.

Senator DONNELL. So you would not, I take it, choose the language if you were doing the choosing in this bill? You would not refer to the scale of the development of research as appallingly inadequate? Am I right in my understanding of your view?

Dr. HAWLEY. No, sir; I do not think I would use those two words.

Senator DONNELL. That is, I am correct in my understanding of your view?

Dr. HAWLEY. Yes, sir.

Senator MURRAY. You would use "desperately" instead of "appallingly," I suppose?

Dr. HAWLEY. I tell you, I think I would consult my Roget, Senator, before I decided on the adjective.

Senator DONNELL. Finally, Doctor, just to take up the seventh one here, a serious maldistribution of both personnel and facilities, so that some areas are disproportionately supplied in relation to others which suffer from an almost total lack of decent medical care; I suppose there are some sections that do not have any medical care?

Dr. HAWLEY. That is true. That is perfectly true.

Senator DONNELL. So that probably has some foundation. Are you able to estimate what proportion of the United States has almost a total lack of decent medical care?

Dr. HAWLEY. Well, I should say—well now, that is a guess, and I am open to attack right here. I would put that considerably under 5 percent of our total population.

Senator DONNELL. Now, doctor, I wanted to ask you something here——

Dr. HAWLEY. May I comment 1 minute on that maldistribution? Dr. Frank Dickenson, who is a medical economist, has just completed a study on this distribution of physicians by trade areas instead of geographical areas.

When you take State boundaries, you can show considerably bad distribution, if you take geographical lines. But his study is based on trading areas. For instance, my home is in Indiana, but 9 out of 10 people requiring hospital care go down to Cincinnati, across the line and down, and it is a trading area where for all purposes we are a part of the State of Ohio.

When you study this distribution of physicians and hospitals by trade areas instead of geographical areas, the maldistribution is not nearly so serious as it appears.

Senator DONNELL. We had some testimony here a year or 2 ago, as I recall, on one of these bills, not one of these here but similar bills before, in regard to a survey that was made by doctors up in New Jersey to find out whether or not there was such a terrible medical condition up there.

Are you familiar with that?

Dr. HAWLEY. No, sir; I am not.

Senator DONNELL. Now, doctor, I want to ask you just briefly something about your own experience, and I think it is important to have it in this record, because there will be lots of people read this record all over the United States.

If you do not mind just telling us, you are from Indiana; you have said that. Would you tell us please where did you take and when did you take your professional training as a doctor?

Dr. HAWLEY. I graduated in liberal arts from Indiana University.

Senator DONNELL. What year was that?

Dr. HAWLEY. 1912. Medicine at the University of Cincinnati in 1914. I was an intern and a resident in the Cincinnati General Hospital, city hospital there; and I took my doctorate in public health at Johns Hopkins in 1923, after I had entered the Army.

My grandfather was a country doctor in southern Indiana in the same town. My father was also; and when I finished, I went back and entered practice with my father, stayed for a year, and then came into the Army in 1916, and served continuously in the Army until 1946.

My last active service in the Army was as chief surgeon of the European theater of operations under General Eisenhower during the entire war in Europe.

I went to the Veterans' Administration as chief medical director with General Bradley in August of 1945, and resigned from that position on the 31st of December 1947. Since April 1, 1948, I have been the chief executive officer of the Blue Cross and Blue Shield Commissions.

Senator DONNELL. Doctor, I wanted to just go back for a minute. When you went back home there to Indiana, did you engage in the general practice of medicine there?

Dr. HAWLEY. General practice of a country doctor, and the reason I left in 1916 was the same reason that people do not go to the country today. You were trained—I spent almost 2 years in a hospital after graduation, and you go out there and you have no X-ray; you have no laboratory. You have your eyes and your ears and your hands, and you feel rather helpless in doing what you would like to do for your patients.

That is the only thing that ever drove me away from the practice of medicine. That is one reason I am so terribly convinced that some way—I do not think that these should be free—I am afraid they are going to have to be subsidized.

I think the people who can afford to pay for diagnostic facilities should pay. I think that once these clinics are established, that the voluntary plans can enable people to have the use of them. I think the diagnostic facilities in rural areas are terribly important. I think that hospital facilities in rural areas are very dangerous, because it invites people of no surgical training to operate on their cases at home instead of sending them into centers where they get better care.

Senator DONNELL. How long did you practice out in Indiana?

Dr. HAWLEY. About a year.

Senator DONNELL. Then you went into the Army in 1916? Did I correctly understand that you took your degree from Johns Hopkins in 1923?

Dr. HAWLEY. After I was in the Army.

Senator DONNELL. Was Dr. Walter Dandy there in the school——

Dr. HAWLEY. This was the school of hygiene, under Welch, Howell, Raymond Pearl; Lowell Reed, who is now the vice president of the university, was professor of biometry at that time.

Senator DONNELL. After you went into the Army, what was your work for the next 10 years or so after you immediately went in? Was that along medical lines?

Dr. HAWLEY. Yes, it was not until about 1931—I kept trying to do clinical medicine in the Army, and in 1929 I was the senior medical officer of the Nicaragua Canal Survey of 1929 to 1931.

Senator DONNELL. That would be for 15 years, up until 1931, that you were working along the lines you have just described?

Dr. HAWLEY. That is right.

Senator DONNELL. Where all did you work besides Nicaragua? What generally did you do in the work with the Army during that 15-year period?

Dr. HAWLEY. It was a pretty varied career, almost checkered, I should say. I served in the Philippines. I took care of patients on certain stations. I was an instructor in the Army Medical School and in Medical Field Service School, both. And until about 1931, when I was made executive officer of the Army Medical Center at Walter Reed Hospital here, and it was continuously being against my will, pushed into administrative positions that made me decide I had perhaps best stay in that and take some other training.

So in 1934 I went to the Command and General Staff School at Leavenworth and graduated there in 1936. It was a 2-year course at that time. In 1938 I went to the War College and graduated in 1939. Afterward, I went back to the Medical Field Service School as an instructor.

Senator DONNELL. In the course of your very wide experience which you have described, did you have opportunity, you think, to judge of the quality, generally speaking, of the professional work and the proficiency of the American physicians with whom you came in contact?

Dr. HAWLEY. Yes.

Senator DONNELL. Did you come in contact——

Dr. HAWLEY. Not only as comparing them with other people. The most impressive experience in my life is having seen medicine and surgery by American physicians in World War I, and in World War II. I would not think it was the same art or science.

The progress of American medicine between these two World Wars has been nothing—and I will use a big one—nothing less than astonishing. In World War II, compared with the medical services offered by our allies and our enemies, there was just no comparison.

Senator DONNELL. That is, you mean ours was better?

Dr. HAWLEY. Oh, infinitely better. I might say right there that I would not be terribly impressed by what the British people thought about their system, because I do not think they have ever had good medical care. Now, they are getting lots more of it right now than they had before.

Senator DONNELL. The same general quality that they had before?

Dr. HAWLEY. I think the quality is less now, but I do not believe for 1 minute that the American people would tolerate a quality of medical care which is given to the British people today. I do not think they would tolerate it a minute.

I say that as a very considered opinion. I was 3 years in England during this war. It is not a fair comparison of a war-torn country, but I think you can judge from the quality of the care given to the armed forces during war what quality of care is given to the civil population between wars.

Senator DONNELL. Right now, as I understand it, they have recently installed some new system over there, but they did have government medicine, government practice of medicine, at the time of the 3 years that you spent there, did they not?

Dr. HAWLEY. That is right.

Senator DONNELL. Do you mind telling us, Doctor, what you observed as to the operation of that governmentally controlled medical service in England during that 3-year period?

Dr. HAWLEY. The most outstanding thing, it seemed to me, was a very much less feeling of responsibility on the part of the individual doctor for his patient. That was very difficult for me to understand; the substitution of correct administrative procedure for good medical care, and that is the thing which we are not free from in this country in our own Federal system of medicine.

You will remember the difficulties that the Veterans' Administration medical service was in about 1945, and the rapid improvement. Now I am going to explain the rapid improvement in a minute.

I was not the only person involved there, but the reason for the difficulties was that administrative excellence and proper forms filled out in veterans' hospitals had substituted for the care of the patient.

Senator DONNELL. Did you observe that same thing in England during that 3 years?

Dr. HAWLEY. "Yes" is the answer, and observers of the present system are reporting the same thing.

Now, as to why the Veterans' Administration improved, it could never have improved within its own resources. It was improved only because we got the cooperation of the free practitioners of this country, medical practitioners who came in and gave from 1 to 15 hours a week in veterans' hospitals. The improvement was not within ourselves, but was from this outside support.

Senator DONNELL. Doctor, to what do you attribute, if not lack, at least decreased sense of personal responsibility on the part of the doctor to his patient in England during those 3 years?

Dr. HAWLEY. I cannot answer that. It may have been something in the general philosophy of medical practice of the country. One thing we have got to remember about Britain, and that is that their system of training and licensure of physicians is quite different from ours. There are all degrees of getting a license to practice. The examinations given by the Royal College of Physicians, the Royal College of Surgeons, are very comprehensive and you must have considerable ability to pass them.

But you go down through various grades of licensure which in no way limits your practice at all. You can practice medicine with any of them, down to the Conjoint Board which I think any good sophomore student in medicine in this country could pass, and get a license to practice.

So you have got many factors. I do not know what causes this indifference. I do not mean to say that it is 100 percent, but it impressed me very much, the lack of intense concern of the doctor over the welfare of his patient, which sometimes does not exist here, but which usually characterizes the relationship of the American physician to his patient.

Senator DONNELL. But you did observe that the excellent paper work, the reporting, and so forth, tended to be emphasized at the expense, in your judgment, of the excellence of the treatment of the patient?

Dr. HAWLEY. That was a very important thing.

Senator DONNELL. And I am correct in my statement, am I?

Dr. HAWLEY. You are, sir.

Senator DONNELL. Now, Doctor, you mentioned in your statement here, the typewritten, mimeographed statement, that during the last half of the nineteenth century the world capital of medicine was in Germany. Doctors from this country went over there to take their degrees and went to Germany right along in those days.

Dr. HAWLEY. Yes.

Senator DONNELL. You say doctors the world over went to Germany to complete their training, and then you say the program of compulsory health insurance was the greatest factor in the loss of this preeminent position.

Let me ask you first, were you personally in Germany——

Dr. HAWLEY. Never, except during this war.

Senator DONNELL. But you have studied the operation of the compulsory-insurance system in Germany?

Dr. HAWLEY. Yes.

Senator DONNELL. May I ask you, Doctor, to what do you attribute the fact that the program of compulsory health insurance was the greatest factor in the loss of the preeminent position of Germany in medicine?

Dr. HAWLEY. Well, the one thing I should say was the regimentation which is bound to come. No matter how beneficent a system like this starts out, and I have not the slightest doubt in my mind that the gentlemen who would like to see compulsory health insurance want to keep it that way, but it is foreign to our own operations; there is more and more regimentation——

Senator DONNELL. Just what do you mean by regimentation?

Dr. HAWLEY. Throttling of free enterprise, free development, forcing people more or less into molds: and right now, with classes of medical students in Germany of a thousand, a thousand men in a class, sitting up listening to a lecture, learning medicine that way.

That is what I am afraid of in this expansion of medical schools. You cannot teach medicine that way. Of course, I would be hard put to prove that statement. That was an expression of opinion, that the compulsory health insurance was perhaps the greatest single factor in the loss of that preeminent position in medicine in Germany.

Senator DONNELL. When you were over in Germany during the war, did you talk with people there about the operation of the system?

Dr. HAWLEY. Yes; and I saw lots of doctors and lots of German wounded, and they were awfully badly treated. I remembered all the years between the two world wars the smell of pus. I had not smelled it in American hospitals in this war until I walked into one along in June of 1945, and opened the door of a ward and walked in. I had not smelled that smell since the First World War, a whole ward full of infected cases. It was a characteristic odor. I turned to the hospital commander and I said, "What in the name of heaven has happened here?" He said, "This is a hospital trainful of American wounded that had been recaptured, treated in German military hospitals. They have only been in 2 days, and they are everyone badly infected."

Senator DONNELL. How long were you in Germany at that time, Doctor?

Dr. HAWLEY. I was never stationed in Germany. I went up very frequently to the front. I was in France from about D–6, which would be about June 12, until I left in August of 1945.

Senator DONNELL. And you went over to Germany frequently during that time?

Dr. HAWLEY. Yes. We saw thousand of German wounded which we overran in the advance, and we took their own medical personnel, gave them our hospitals, and moved out and saw their own care and treatment of their own wounded.

Senator DONNELL. So you observed the type of treatment they gave and talked with some of them and you saw literally thousands, I take it, of persons who were wounded and treated?

Dr. HAWLEY. It was a very low quality of medical care.

Senator DONNELL. Now, Doctor, earlier this afternoon, Senator Pepper asked you a question. I cannot recall it with exactitude, and I may give it somewhat the wrong slant here. If I do, it is unintentional.

But my recollection is to the general effect that he inquired of you along this line, as to whether it is not a fact that inasmuch as a person under this compulsory health insurance plan could go to a doctor that was not in the system, that there is an answer by reason of that fact to the objection that the person does not have freedom of choice.

You said, as I remember, if that was not the question, you said at sometime that there were two reasons why the explanation that he suggested did not answer the problem.

One of them was you said that doctors will either go in or starve. Do you remember that part of your testimony?

Dr. HAWLEY. Yes.

Senator DONNELL. Do you remember now just what that reason was you were going to assign?

Dr. HAWLEY. There were two reasons why members of the Catholic faith on the question of public education versus parochial education——

Senator DONNELL. Pardon me, Doctor. I do not think that was the point I was inquiring about. You said doctors would have to go into this or starve.

Dr. HAWLEY. That is right.

Senator DONNELL. I just wanted to pursue that point a little bit further. Why do you think they would have to go in if this compulsory health system were put into effect?

Dr. HAWLEY. I do not believe any great number of people are going to contribute 1½ percent of their income with the idea of gettting medical service without further cost, and then turn around and pay the costs of private practitioners; although there are people in Britain who are now being forced to do that in order to get medical care within any reasonable time.

Senator DONNELL. Have you talked with people from England who have observed English persons and learned that?

Dr. HAWLEY. Yes.

Senator DONNELL. Doctor, referring to the effect of the compulsory health insurance program in this country, what would be the effect in your opinion of such a program on this voluntary plan of Blue Cross and Blue Shield, and so forth? What do you think would be the effect?

Dr. HAWLEY. As Senator Pepper and I were talking, he said he would be very glad to consider a way whereby they could be incorporated. At the moment, as the bill stands, I do not see any possibility for them existing one moment after it goes in.

Senator DONNELL. That is, if the compulsory health insurance bill, S. 1679, goes in, the way it is now written, in your opinion that is the end of the voluntary plan such as Blue Cross and Blue Shield? Is that right? Am I right in that?

Dr. HAWLEY. That is true. The great bulk of our subscribers are employed people or wage earners, the ones who would first be taxed by this bill. And they are not, and neither is their employer if he is contributing now to part of the cost, going to contribute 1½ percent pay roll to a compulsory system and turn around and pay any part of the benefits or any part of the subscription to a voluntary system.

Senator DONNELL. Doctor, just one or two further points. What was it understood Mr. Cruikshank to testify to whether the system of medicine in England in operation now is a socialized system? What did you understand him to say?

Dr. HAWLEY. I understood Mr. Cruikshank to say—you can check this from the record—that it was not socialized because there was no contribution of the individual person to the medical fund, that there was no direct contribution. For example, there is a general social insurance tax in England, but that no part of this was earmarked for medicine, and that the entire cost of that care was paid by appropriations from the general revenues of the Government.

Senator DONNELL. Did you understand him to draw the conclusion from that that it is socialized or it is not socialized?

Dr. HAWLEY. That was his reason it is not socialized—or that it was socialized. I am terribly sorry. He said it was socialized because it is all paid for out of general revenues of the Government.

Senator DONNELL. I remember when you testified in response to some questions from either Senator Murray or Senator Pepper, I understood you to say that Mr. Cruikshank had testified that it was not socialized. I understood him directly to the contrary, and I see now that your understanding——

Dr. HAWLEY. You are quite right. If I stated that, it was wrong.

Senator DONNELL. You proceeded to say that Mr. Cruikshank is wrong in his understanding of the facts, that is right, that some of this money is not contributed out of the public treasury——

Dr. HAWLEY. Directly by the citizens. That is true.

Senator DONNELL. Now, Doctor, Senator Murray presented here some clipping from some columnist. Do you mind telling us, Senator Murray, who that was, if you have it at hand?

Senator MURRAY. The columnist that wrote this article is Lowell Mellett. He is just quoting an article from the paper which told about resolutions adopted by the National Fraternal Congress of America.

Senator DONNELL. I just wanted at this point to ask the chairman if I might introduce into the record and have incorporated therein a clipping from The Evening Star, Washington, December 20, 1948, by Dorothy Thompson, entitled "On the Record—Compulsory Health Insurance Opposed as Being Costly and Impractical."

May I have that incorporated?

Senator MURRAY. Yes, and this one, too.

(The two newspaper clippings above-mentioned are as follows:)

ON THE OTHER HAND—SOME REMARKABLE THINGS BEING DONE IN NAME OF FAMILY DOCTORS

(By Lowell Mellett)

Doctors are pretty decent people. In the minds of most of us they measure up to the conception of the familiar picture, the Doctor, which shows the family physician at the bedside of the little child. The doctor is our friend and he's all right. And if he wants to hang a copy of that painting—furnished by AMA—

in his waiting room with a placard attached reading, "Keep politics out of this picture," that's all right, too. After all, he is entitled to something in return for the $25 he contributes to the American Medical Association's propaganda fund.

No question about the doctors being fine folks. But for downright dishonesty it would be hard to equal some of the things now being done in their name.

RESOLUTION CITED

One of the latest examples is offered in a resolution adopted by the executive committee of the National Fraternal Congress of America and given general distribution through fraternal channels. The resolution reads, in part:

Whereas one of the subjects now being considered by the Congress of the United States is that of socialized medicine; and

"Whereas socialized medicine has been defined by Oscar Ewing, Federal Security Administrator, as follows: 'Socialized medicine means that the doctors are salaried employees of the Government. As their employer, the Government can direct and control any detail of their work. All medical services are controlled by the Government and medical care is furnished to citizens through the Government' * * *."

After some more whereases, there is this:

"Whereas the health insurance proposal at the national level, known as socialized medicine, as above described, would mean doing away with the present intimate and confidential relationship between patient and physician."

Then follows the usual set of alarms conjured up by the AMA against national health insurance and a ringing declaration in favor of private enterprise in the practice of medicine.

POSITION MISREPRESENTED

The dishonesty in all this lies in its flagrant misrepresentation of Mr. Ewing's position and of the administration's health insurance plan. In the January issue of the American Druggist, Mr. Ewing defined socialized medicine in the language quoted by the resolution. But he did it in order to demonstrate that the Government's proposal would provide something very different.

The American Druggist presented his position fairly enough and it was not possible for the executive committee of the National Fraternal Congress to misunderstand it. The resolution was drafted, nevertheless, with instructions that copies be sent to members of any congressional committee considering the subject. Such committee members, of course, will readily recognize the attempted deception. But they probably will not escape an avalanche of mail from constituents who have been fooled; not if the Fraternal Congress is correct in its claim to represent 110 benefit societies with a total membership of 10,000,000 persons.

Getting back to your family doctor, the AMA is undertaking to persuade the personal physicians of every Member of the House and Senate to write them personal letters describing the dangers of socialized medicine. Presumably, however, Dr. George W. Calver and his staff, who take care—at the Government's expense—of the Members while they are in Washington, will not be among those asked to write letters.

[From the Washington Evening Star, December 20, 1948]

On the Record—Compulsory Health Insurance Opposed as Being Costly and Impractical

(By Dorothy Thompson)

It seems certain that we are going to take another step on the road to bureaucratic collectivism by the passage of a compulsory health insurance bill, to which President Truman is pledged.

The United States Public Health Service is for it, as every Government agency is always for a vast extension of its powers. The labor unions and farmers' organizations are for it because it sounds good. Industry would like to saddle the Federal Government with the expense of workmen's compensation cases. Professional social workers foresee great opportunities for themselves. And a mere 150,000 physicians, 90 percent of whom are against it, cannot buck the trend. Besides, they are supposed to be "prejudiced," on the current theory that those who know most about anything are not reliable witnesses.

Also, the opposition has not been intelligent. It has ranted against socialization as though the mere word had conjuring powers. Let this opponent, therefore, make herself clear. I am not against compulsory health insurance because it is socialistic, but because it is the application of national socialism in the least appropriate field. Also, I have lived under such medical systems in England, Austria, and Germany, and they were awful.

COST TOO MUCH

They cost the people far too much. They provide inferior services at a high price. They are incapable of dealing with really serious and complicated cases. They result in two sorts of medicine—good medicine for the well-to-do, and bad for the masses, at high cost to those who can least afford it. And they build up a vested interest of physicians and bureaucrats which the people will never get rid of.

The great joker in all these schemes is that they are put forward as "free," meaning something for nothing. Let their proponents at least tell the truth. What is advocated is compulsory insurance.

Every worker in this country will have the cost subtracted from his pay envelope, and added (by his employers) to the price of everything he buys. He will be paying for unused aspirins when he needs the money for oranges. He will be supporting innumerable filing clerks—a horrendous paper staff for 150,000,000 people. When and if he gets ill, he will find himself as one of 50 patients (half of them hypochondriacs bent on getting service for their money) whom a physician must examine in an hour.

And if he really is ill—and finds that under the slap-happy methods of overworked doctors, whose fees are assured anyhow, he gets not better but worse—he finally will, in desperation, consult one of those private physicians who refuse to join the assembly line and, atop all he already has put up, week by week, pay a private fee.

How do I know this? Because I have experienced it.

BETTER SERVICE NEEDED

Just why this most inventive country seems compelled blindly to copy social measures originating elsewhere is baffling. We need many, many more hospitals. The existing hospitals need public aid, since the sources of private support are increasingly drained off in taxes. And we need more genuinely free medicine for people in real jams.

But before Congress passes any bill for universal sickness insurance—falsely called "health" insurance—it owes it to the American people to tell them exactly what a person with, say, an income of from $2,000 to $3,000 a year is going to have to pay over a working life of 40 years to take care of his illnesses, and just what services the Government positively guarantees him in return for his money. Will it, for instance, sign on the dotted line that if his wife is in labor, the Government guarantees a bed and a physician at the critical moment?

Don't make me laugh. I've lived under these schemes.

(Released by the Bell Syndicate, Inc.)

Senator Donnell. In connection with Miss Thompson's article, I want to emphasize this:

> Also, the opposition has not been intelligent. It has ranted against "socialization" as though the mere word had conjuring powers. Let this opponent, therefore, make herself clear. I am not against compulsory health insurance because it is "socialistic," but because it is the application of national socialism in the least appropriate field. Also, I have lived under such medical systems in England, Austria, and Germany, and they were awful.

Did you get over to Austria, General?

Dr. Hawley. No; I did not.

Senator Donnell. You spoke about being associated with General Eisenhower. Just what was your capacity there with General Eisenhower?

Dr. Hawley. I was the chief of the medical service in that theater.

Senator Donnell. And you had under you all the doctors and surgeons in that entire European theater?

Dr. HAWLEY. Yes, with due latitude to any army organization of command and technical control; yes, I was responsible to him for their medical service and had supervision of them.

Senator DONNELL. For how long did you occupy that office?

Dr. HAWLEY. I went to England before Pearl Harbor on a military mission. I was there when we got into the war, and immediately the theater was organized under one or two names that were changed before it became the theater of operations—first it became the United States Army forces in the British Isles; and constantly from January 1942 until I left in August 1945, I was the head of the medical service in Europe of the American Army.

Senator DONNELL. Doctor, Senator Taft referred to you, and I think one or two of the other gentlemen, as General. Would you mind stating for the record the exact military title you have?

Dr. HAWLEY. I am a major general, United States Army, retired.

Senator DONNELL. Doctor, I thank you very much for the testimony.

Senator MURRAY. Doctor, I would like to inquire, what year did you enter the Army?

Dr. HAWLEY. 1916, sir.

Senator MURRAY. How long had you been practicing medicine before that?

Dr. HAWLEY. Well, if you exclude my almost 2 years in the Cincinnati hospital, I started to practice on the 15th of December 1915, and went in the Army on October 10, 1916. I had been licensed to practice medicine since June of 1914.

Senator MURRAY. While you were in the Army you gained considerable experience in medical practice?

Dr. HAWLEY. Well, I would not put it——

Senator MURRAY. You have achieved a considerable reputation.

Dr. HAWLEY. The experience was varied.

Senator MURRAY. You are recognized in the country as a doctor of considerable ability. Is that not true?

Dr. HAWLEY. Senator, that depends on what is the matter with you.

Senator MURRAY. You do not intend to tell us now you are not a good doctor; do you?

Dr. HAWLEY. If you have certain things the matter with you, I advise you to consult someone else.

Senator MURRAY. While you were in the Army, did you observe the character of the medical care that was given by the surgeons and medical profession there during that period that you were in the Army?

Dr. HAWLEY. Yes, sir.

Senator MURRAY. And you found that that was very excellent?

Dr. HAWLEY. I said during the war. I do not want to be disloyal, and I think that all of us who served in the Army would agree with this, with the system of controlled medical care such as the Army had, we never did and never could attain the quality of medical care that you expect to find around medical centers in this country. It was a great deal better than, a higher quality than, is practiced in some areas in the country perhaps.

The Army's great contribution to medicine has been in the field of preventive medicine.

Senator MURRAY. You say there was a tremendous advance following the First World War and in the Second World War the medical practice in the Army then was much superior?

Dr. HAWLEY Very much.

Senator MURRAY. And all during the last war, the doctors in the Army rendered unusually good service?

Dr. HAWLEY. I think it was splendid. It was really almost unbelievable in Europe.

Senator MURRAY. Did they not acquire a lot of knowledge and information that was of great value to the profession?

Dr. HAWLEY. Yes.

Senator MURRAY. So all during the war the practitioners in the Army were doing an excellent job?

Dr. HAWLEY. They certainly were in the European theater, a superlative job.

Senator MURRAY. And they were all under the pay of the United States Government?

Dr. HAWLEY. That is true.

Senator MURRAY. Working on a salary basis?

Dr. HAWLEY. That is right; yes, sir.

Senator MURRAY. And that did not interfere with them giving the best possible care that they could give to the American soldier?

Dr. HAWLEY. Within the limit of time and under the additional incentive, of course, of public service at that time, that is true.

Senator MURRAY. Would you say that the quality of the service rendered by the British doctors was very poor?

Dr. HAWLEY. No, Senator; I did not mean to say that.

Senator MURRAY. This record is going over to the British. If you want to correct it, you are at liberty to do so.

Dr. HAWLEY. No; I will not correct that. If I said it, I did not say what I meant. I said it was not nearly of as such high quality as this country. I said that the people of Great Britain did not really know what first-class medical care was because on the whole, for years in my opinion they have been receiving poor medical care. Now, that is a broad generality.

Senator MURRAY. Was that because of poor medical care or education?

Dr. HAWLEY. No; you see, I said nothing about medical education.

Senator MURRAY. You said English doctors were inferior to the American doctors.

Dr. HAWLEY. That I stand on. That is true. The reason for that is not in the facilities for medical education, but in the method of licensure. They do not have standard and controlled instruction in their medical schools that we have.

Senator MURRAY. So the men practicing medicine over there are not of such high quality physicians——

Dr. HAWLEY. I do not think they average anywhere nearly as well-trained as in this country.

Senator MURRAY. And you had plenty of opportunity to study their practice over there and see the results of their work during the war. That is the First World War you are talking about?

Dr. HAWLEY. No; the Second World War. Enough to give me that rather firm opinion, sir.

Senator MURRAY. You do not want to now say that the medical care rendered by the British medical profession is of a very low character?

Dr. HAWLEY. No; but I say it is distinctly of a lower character than is given in this country.

Senator MURRAY. How do you explain that? Is it that their medical schools there are not up to par, that they have not got the facilities for training doctors there like we have in this country?

Dr. HAWLEY. No; they have not the facilities for graduate education and the training of specialists that we have in this country, No. 1. No. 2, their system of medical education might best be described as laying it out on the table and help yourself.

They do not have the system of rigid examinations within the schools that we have here, and then their system of licensure which is not a state function in Britain but which is delegated to a large number of agencies varies in its thoroughness of examination from a very rigid examination, which is probably more rigid than some of the State examinations in this country, down to a very low level of examinations, which I said that I thought many sophomore students in this country could pass.

Senator MURRAY. Then you think that the medical care given by the doctors of England cannot be compared with the medical care rendered in this country?

Dr. HAWLEY. I believe that very firmly, sir.

Senator MURRAY. And of course that applies today as it did before——

Dr. HAWLEY. That is true. Except as the facilities are now being strained, there is even less attention able to be given to each patient who applies. I do not think that that is a product of their nationalization of the medical care. I think that existed before. I do not mean to leave that impression at all.

But I do think that even those facilities that I think were lesser quality than ours are now being overstrained by the tremendous demand.

Senator MURRAY. And by the lack of sufficient doctors, and so forth?

Dr. HAWLEY. That is right; yes.

Senator MURRAY. That is all. Thank you.

(Subsequently Senator Murray submitted the following material for inclusion in the record:)

JUNE 23, 1949.

Dr. PAUL R. HAWLEY,
Chief Executive Officer, Blue Shield Commission of Associated Medical-Care Plans, Chicago, Ill.

DEAR DR. HAWLEY: In connection with the study of legislative health proposals being considered by the Subcommittee on Health of the Senate Committee on Labor and Public Welfare, I am desirous of obtaining authoritative and up-to-date information and statistics on the operation of nonprofit prepaid medical-care plans. I find that the information which has been made available to us thus far is incomplete and confusing.

I understand that there is a total of 72 medical-care plans affiliated with your organization; and I also understand that some of these plans operate through the approval of insurance contracts or policies made available to the public by commercial insurance companies. I would appreciate having a list of the affiliated plans, divided into three categories: (*a*) those which use only commercial insurance companies; (*b*) those (if any) which use commercial insurance companies, but also make other arrangements to provide benefits; and (*c*) all the remaining plans affiliated with AMCP. Would you also identify the sponsorship (Blue Shield, Blue Cross, or "other") of each name on the total list?

I have prepared a list of items of information (schedule I) which I would like to have about each of the plans which uses commercial insurance policies, and shown in category (*a*) of the list requested above. Will you please supply me with this information for the year 1948?

Will you also please furnish me data, for 1948, on each of the plans, affiliated with Associated Medical Care Plans, and shown in category (*c*) of the list requested above. I would like to have for each of these plans the items indicated on the enclosed schedule (schedule II). If the data are not available for some of the plans, please furnish the data for as many as possible.

I would also like to have aggregates of some of the items requested in schedule II—namely, for all plans to which this schedule applies, the combined data for item 1 and for items 7–12, inclusive, on schedule II. If these totals do not represent all plans, please indicate which plans are omitted.

If there are plans which fall into category (*b*), will you please use schedules I or II for the respective part of each plan's operation, as it applies?

In all cases the data should be confined, if possible to the United States, and identified as going beyond the United States where this limitation cannot be observed. Also, if the data cannot be furnished in the form requested on the schedules, I should be glad to have them in the form in which they are available, with appropriate explanatory notes.

We expect to conclude the hearings on health legislation on June 29. Therefore, I would appreciate having this information as soon as possible. Should there be unavoidable delay in supplying part of it, please send as much as possible as soon as it is ready.

With my thanks for your cooperation.

Sincerely yours,

——— ———.

SCHEDULE I

(*a*) The names of the insurance companies any of whose contracts or policies are approved by the particular plan.

(*b*) Information on the nature of the use which the insurance companies may make of Blue Shield or Blue Cross approval or endorsement.

(*c*) Sample copies of the approved or endorsed insurance contracts or policies.

(*d*) Number of participants or persons enrolled (subscribers and dependents separately) under approved insurance contracts or policies. (Please indicate whether the figures are averages for the year or the numbers on specified dates.)

(*e*) Total premium payments under approved contracts or policies.

(*f*) Total "losses" (benefits) paid to policyholders by insurance companies under approved insurance contracts or policies (include payments to physicians, if any such are paid to them instead of to policyholders).

(*g*) Total expenditures incurred in the administration or operation of the particular plan (exclusive of the insurance company operations).

SCHEDULE II

1. Number of participants or persons enrolled (subscribers and dependents separately). (Preferably the average number for the year; otherwise the numbers on stated dates).
2. Urban-rural distribution of participants.[1]
3. Distribution of participants by size of city (if available).
4. Distribution of participants by income groups or any available indication of income distribution.
5. Services provided to (*a*) subscribers (*b*) dependents.
6. Premiums charged, indicating whether or not there are income limits, and whether or not additional charges may be made by the physician.
7. Total income from participants or subscribers.[1]
8. Total payments as benefits provided under the contracts.[1]
9. Additions to reserve.[1]
10. All administrative expenses.[1]

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[1] For these items, aggregrates to be shown in a separate table, for all plans for which all of these items are available.

11. Other (if any, to balance income, disbursements and additions to reserve).[1]
12. Total reserves (on stated dates).[1]

BLUE CROSS COMMISSION OF THE AMERICAN HOSPITAL ASSOCIATION,
BLUE SHIELD COMMISSION OF THE ASSOCIATED MEDICAL CARE PLANS,
Chicago, Ill., June 28, 1949.

Hon. JAMES E. MURRAY,
United States Senate, Washington, D. C.

DEAR SENATOR MURRAY: I have accumulated the information you requested as rapidly as possible. The answers to some of your questions required considerable search; and, unfortunately, I am not able to answer a few. I do hope this reaches you in time.

Associated Medical Care Plans is a federation of nonprofit plans, and only nonprofit medical-care plans actively sponsored by local, State, or county medical societies are eligible for membership in Associated Medical Care Plans. Commercial insurance companies are not eligible. There are 64 Blue Shield plans (62 in the United States, Hawaii, and Puerto Rico, and two in Canada). There are a total of 79 nonprofit medical-care plans as of this date (74 in the United States, Hawaii, and Puerto Rico, and five in Canada). Some of the 15 nonmembers of AMCP are ineligible for membership for one or another reason, and some are eligible but have not applied for membership in AMCP. In the quarterly enrollment and financial reports prepared by AMCP, data from all nonprofit plans, regardless of affiliation, are reported.

The Blue Shield Directory, which I inclose, gives a list of all the 64 Blue Shield plans. For a listing of all the plans indicated above, I invite your attention to the Blue Shield enrollment reports, first quarter 1949. Table I lists 73 nonprofit plans, of which 59 are Blue Shield plans. The footnotes of table I of the enrollment reports indicate (**) nonmembers of AMCP that are not affiliated with Blue Cross; (##) members of AMCP that are not affiliated with Blue Cross, and (#) nonmembers of AMCP which are operated by, or affiliated with, Blue Cross. All plans not footnoted are Blue Shield plans affiliated with Blue Cross. Table III gives a quick summary of the number of plans so affiliated.

The listing referred to in the paragraph above, which covers 73 plans, is as of March 31, 1949. Since that date, six new plans have been established and will be enrolling subscribers during the second or third quarter. These plans are located at: New Haven, Conn.; Rockford, Ill.; Moline, Ill.; Louisville, Ky.; Greenville, S. C.; and Chattanooga, Tenn. All of these new plans are affiliated with Blue Cross plans, and all are Blue Shield members except the plan located at New Haven, Conn.

The preceding information accounts for 79 nonprofit plans, of which 64 are members of AMCP and known as Blue Shield plans. In addition there are three other plans in the process of being organized. These plans are located at Alton, Ill.; Chautauqua, N. Y.; and Kingsport, Tenn. These plans will probably be eligible for Blue Shield membership and are expected to apply.

The figure of 72 medical-service plans, used in your letter, was the number of plans in operation December 31, 1948, as reported in table I of the enrollment report for the year 1948, a copy of which is enclosed.

None of the Blue Shield plans, or other nonprofit plans, reported in our financial or enrollment tables has any connection with commercial insurance companies. Commercial insurance plans are not eligible for Blue Shield membership, even though approved by local medical socieites. Commercially underwritten plans are operating in: Rhode Island, Wisconsin, South Dakota, Toledo, Ohio; Illinois, Tennessee (just started), and Maine (not active). Since we have no connection with commercially underwritten plans, it will be impossible for us to provide answers to all of the items outlined in your schedule I. I have enclosed a copy of the 1949 edition of Voluntary Prepayment Medical Care Plans, prepared by the council on medical service of the American Medical Association. The council awards its seal of acceptance to both nonprofit plans (acceptable for Blue Shield membership) and commercially underwritten programs (not acceptable for Blue Shield membership).

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[1] For these items, aggregrates to be shown in a separate table, for all plans for which all of these items are available.

This booklet will answer some of your questions in schedule I regarding commercial insurance company programs. Following are schedule I replies:

(*a*) The names of the commercial companies involved are not available. In some States, a number of different companies participate in the program.

(*b*) These plans are not eligible for Blue Cross or Blue Shield approval.

(*c*) Sample policies are not available. The booklet Voluntary Prepayment Medical Care Plans, summarizes the benefits.

(*d*) See Voluntary Prepayment Medical Care Plans.

(*e*), (*f*), and (*g*) Limited financial information is available for only two of the commercial plans:

Toledo, Ohio, 1948 operating information

Income	$552, 477
Claims paid	338, 470
Operating expense	96, 083
Reserve for maternity	82, 872

The Wisconsin plan (cumulative data for 1947, 1948) (accrual basis)

Income	$3, 201, 280
Claims paid	2, 707, 576
Operating expense	700, 428
Cumulative loss ratios:	*Percent*
To Dec. 31, 1947	80. 8
To July 1, 1948	83. 1
To Dec. 31, 1948	84. 6

I suspect that these data could be obtained only from the commercial companies. The 1949 Argus chart, which I enclose, contains the financial information of commercial insurance companies and their accident and health programs. This is not broken down for hospitalization or medical insurance experience, however. Information on the medically sponsored commercial programs can be found on the following pages in Voluntary Prepayment Medical Care Plans: Rhode Island (p. 68); Wisconsin (p. 86); South Dakota (p. 69); Toledo, Ohio (p. 62); Illinois (p. 28); Tennessee, no information, just started; and Maine, no information, not active.

Following are replies to the questions asked in schedule II:

1. See table I of enrollment reports, either for the year 1948 or for the first quarter 1949, for detailed figures.

	Subscribers	Dependents	Total
Dec. 31, 1948:			
72 plans	4, 564, 824	5, 643, 562	10, 367, 464
60 blue shield plans	3, 979, 080	5, 013, 441	8, 995, 021
58 blue shield plans in United States and Territories	3, 904, 965	4, 909, 941	8, 817, 406
Mar. 31, 1949:			
73 plans	4, 961, 788	6, 200, 777	11, 333, 758
59 blue shield plans	4, 303, 958	5, 458, 082	9, 764, 540
57 blue shield plans in United States and Territories	4, 226, 651	5, 350, 847	9, 579, 998

2. Blue Cross estimates that rural enrollment is somewhat more than 2,500,000. Applying a proportionate percentage to Blue Shield would indicate a rural enrollment of more than 800,000 members. No accurate figures are available.

3. Not available.

4. Not available.

5. In most instances the same benefits accrue to the dependents as to the subscriber. For a brief listing of benefits refer to Voluntary Prepayment Medical Care Plans.

6. See Voluntary Prepayment Medical Care Plans for this information. Where there are income limits, a participating doctor will not make additional charges to an underincome subscriber. A short time ago we made a summary of Blue Shield plan benefits. At that time there were 56 Blue Shield plans in the United States. Thirty-three of these fifty-six Blue Shield plans provided medical-surgical benefits. Of these 56 plans, 7 provide full-service benefits, 1 provides full-service benefits except when the patient selects more expensive hospital accom-

modations than provided by the hospital contract, 28 provide full-service benefits to underincome subscribers, and 20 are cash indemnity. (The income limits per year specified by the 28 plans vary from $1,500 to $3,000 for a single person to $2,400 to $5,000 for a family.) In addition to medical-surgical care, the following benefits were provided by the 56 Blue Shield plans:

Benefit:	*Number of plants*	Benefit:	*Number of plants*
X-ray (diagnostic)	40	Consultants' benefits	6
Anesthesia	34	Ambulance service	6
Laboratory examinations	17	Dental services (Oregon plans)	5
Medical examinations	14	Assisting surgeon	3
Medical treatment	10	X-ray (therapeutic)	3
Radium therapy	7		

Average Blue Shield rates are:

	Monthly	Annually
Surgical:		
Single	$0.80	$9.60
2-person	1.56	18.72
Family	2.06	24.72
Medical—surgical:		
Single	1.17	14.04
2-person	2.26	27.12
Family	2.75	33.00

7, 8, 9, and 10. See table II in the financial report enclosed. This report covers 65 plans. A subtotal for the 55 United States Blue Shield plans has been added. We were unable to obtain data from all 72 nonprofit plans in operation on December 31, 1948.

11. No other adjusting items reported except total income is equal to Earned Income plus Other Income (earnings on bonds, and so forth.)

12. See table I of the financial report or table III where reserves are reported separately.

Since all information in Blue Shield reports is copyrighted, I now give you our permission to use it. Please feel free to ask me for any information at any time.

I should like to take this occasion to express to you my deep appreciation of the courtesy with which I was received by you and your subcommittee. I regret very much that we do not agree upon the solutions of these problems; but I do not need to assure you that this is no wise lessens my esteem for you.

With kindest personal regards,

Sincerely yours,

Paul R. Hawley, M. D.,
Chief Executive Officer, Blue Cross-Blue Shield Commissions.

ENROLLMENT REPORTS—BLUE SHIELD PLANS

First Quarter 1949

(Tabulated by the Associated Medical Care Plans, the National Association of Blue Shield Plans)

Blue Shield Enrollment March 31, 1949

(Including data of 14 nonmember plans)

There were 60 Blue Shield plans on March 31. However, since New Mexico Physicians Service has withdrawn its membership no enrollment is reported for this plan.

Enrollment information is reported for 14 nonmember plans including two Canadian plans not heretofore reporting, the plans at Toronto, Ontario, and Moncton, New Brunswick.

Total enrollment in these medical service plans at the end of the first quarter was 11,333,758. During the first quarter 927,130 new members were added. This represents a growth of 8.82 percent.

The New York City plan again led the way by enrolling 165,683 new members in the first quarter.

The following plans added 40,000 or more new members:

	Members
St. Paul, Minn	51,045
Denver, Colo	47,077
Harrisburg, Pa	46,641
Seattle, Wash	42,129
Newark, N. J	40,309

Table III shows the growth in enrollment of Blue Shield and non-Blue Shield plans divided between those affiliated and those not affiliated with Blue Cross. Fifty-nine Blue Shield plans added 780,369 new members, a growth of 8.69 percent. Fourteen non-Blue Shield plans added 146,761 new members, a growth of 10.32 percent.

In table IV Delaware still heads the list with 48.72 percent of the State's population enrolled. It is encouraging to note the number of new plans that are rapidly increasing their enrollment percentage.

Table V shows the membership and growth of medical service plans by District.

A number of new medical service plans are being organized. It is expected that several will be in operation by June 30. These new plans will give added impetus to current rapid gains in membership.

LYNN DOCTOR,
Assistant to the Actuary.

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TABLE I.—*Membership data of Blue Shield plans and other nonprofit plans, listed alphabetically by States, Mar. 31, 1949*

Plan headquarters	Subscribers	Dependents	Total membership	Members per contract
Alabama, Birmingham	*67,913	*83,357	*151,270	2.23
Arizona, Phoenix	12,700	23,652	36,352	2.36
Arkansas, Little Rock	842	1,267	2,109	2.50
California:				
Oakland#	141,728	165,169	306,897	2.17
San Francisco	373,636	356,858	730,494	1.96
Colorado, Denver	93,316	149,970	243,286	2.61
Delaware, Wilmington	59,531	85,194	144,725	2.43
Florida, Jacksonville	41,054	54,622	95,676	2.33
Idaho, Lewiston**	5,893	6,693	12,586	2.14
Illinois, Chicago	20,361	21,748	42,109	2.07
Indiana, Indianapolis	97,329	154,769	252,098	2.59
Iowa, Des Moines	47,125	59,487	106,612	2.26
Kansas, Topeka	44,279	73,949	118,228	2.67
Louisiana, New Orleans:				
(Louisiana Physicians Service)	8,925	15,031	23,956	2.68
(Hospital Service of New Orleans)#	21,169	28,618	49,787	2.35
Massachusetts, Boston	340,239	*425,299	*765,538	2.25
Michigan, Detroit	533,745	795.299	1,329,044	2.15
Minnesota, St. Paul	*60,026	*91,685	*151,711	2.53
Mississippi, Jackson	12,120	16,844	28,964	2.39
Missouri:				
Kansas City	96,627	115,953	212,580	2.20
St. Louis	82,255	88,256	170,511	2.07
Montana, Helena	34,090	50,981	85,071	2.50
Nebraska, Omaha	30,958	43,032	73,990	2.39
Nevada, Reno**			16,685	
New Hampshire, Concord	77,729	96,548	174,277	2.24
New Jersey, Newark	114,821	162,092	276,913	2.41
New Mexico, Albuquerque#	4,544	7,725	12,269	2.70
New York:				
Albany#	23,593	31,364	54,957	2.33
Buffalo	68,421	*105,779	*174,200	2.55
New York	647,655	646,995	1,294,650	2.00
Rochester	32,554	44,467	77,021	2.37
Syracuse	8,679	12,332	21,011	2.42
Utica	52,293	63,553	115,846	2.22
North Carolina:				
Chapel Hill	136,319	195,455	331,774	2.43
Durham#[1]	73,125	103,664	176,789	2.42
North Dakota, Fargo	3,472	6,142	9,614	2.77
Ohio:				
Cleveland#	41,333	53,021	94,354	2.28
Columbus	205,375	293,928	499,303	2.43
Oklahoma, Tulsa	48,918	80,018	128,936	2.64

See footnotes at end of table.

TABLE I.—*Membership data of Blue Shield plans and other nonprofit plans, listed alphabetically by States, Mar. 31, 1949*—Continued

Plan headquarters	Subscribers	Dependents	Total membership	Members per contract
Oregon:				
Coos Bay##[2]	7,862	241	8,103	----------
Eugene##	7,850	1,679	9,529	1.21
Klamath Falls##	*6,200	*2,482	*8,682	1.40
Oregon City##[2]	----------	----------	*2,500	----------
Portland# (Northwest Hospital Service)	17,358	20,264	37,622	2.17
Portland## (Oregon Physicians Service).	79,786	31,211	110,997	1.39
Pennsylvania, Harrisburg	183,514	216,770	400,284	2.18
Tennessee, Memphis#	4,234	5,258	9,492	2.21
Texas, Dallas## (Dallas County Medical Plan).	1,986	242	2,228	1.12
Dallas (Group Medical and Surgical Service.)	63,740	102,267	166,007	2.60
Utah, Salt Lake City	12,901	22,513	35,414	2.75
Virginia:				
Richmond	73,205	96,606	169,811	2.32
Roanoke	28,503	49,437	77,940	2.73
Washington, Seattle**[3]	170,563	131,776	454,347	2.66
West Virginia:				
Bluefield	3,010	4,424	7,434	2.47
Charleston	18,671	32,936	51,607	2.76
Clarksburg##	3,259	4,805	8,064	2.47
Fairmont##	5,987	11,456	17,443	2.91
Huntington[4]	13,701	24,705	38,406	2.80
Morgantown##	1,082	1,471	2,553	2.36
Parkersburg	8,367	14,036	22,403	2.68
Wheeling	12,786	15,983	28,769	2.25
Wisconsin:				
Madison	50,855	68,065	118,920	2.34
Milwaukee	*84,614	*112,766	*197,380	2.33
Wyoming, Cheyenne	3,857	6,556	10,413	2.70
District of Columbia, Washington, D. C	63,569	71,344	134,913	2.12
Hawaii, Honolulu##	15,436	14,783	30,219	1.96
British Columbia, Vancouver##	54,779	77,555	132,334	2.42
Manitoba, Winnipeg##	22,528	29,680	52,208	2.32
Quebec, Montreal#	126,043	156,363	282,406	2.24
Ontario, Toronto#	12,929	14,036	26,965	2.09
Moncton, New Brunswick#	15,318	18,744	34,062	2.22
Puerto Rico, San Juan	22,603	29,507	52,110	2.31
Total, 73 plans	4,961,788	6,200,777	11,333,758	2.29
59 Blue Shield plans	4,303,958	5,458,082	9,764,540	2.27

[1] Includes hospital enrollment.
[2] December 31 enrollment figure.
[3] Includes 152,008 welfare members.
[4] Includes Ashland, Ky., enrollment figures. Plan operated from Huntington office.
*Estimated.
**Nonmembers of Blue Shield not affiliated with Blue Cross.
#Nonmembers of Blne Shield operated by or affiliated with Blue Cross.
##Blue Shield members not affiliated with Blue Cross.

TABLE II.—*Blue Shield plans and other nonprofit plans listed by size, showing first quarter growth for 1949*

	Total membership	First-quarter growth	
		Members	Percent
200,000 or more members:			
Michigan, Detroit	1,329,044	17,233	1.31
New York, New York	1,294,650	165,683	14.68
Massachusetts, Boston	*765,538	21,251	2.86
California, San Francisco	730,494	30,496	8.51
Ohio, Columbus	499,303	34,036	7.31
Washington, Seattle**[1]	454,347	42,129	10.22
Pennsylvania, Harrisburg	400,284	46,641	13.19
North Carolina, Chapel Hill	331,774	34,582	11.64
California, Oakland#	306,897	25,378	9.01
Quebec, Montreal#	282,406	27,465	10.77
New Jersey, Newark	276,913	40,309	17.04
Indiana, Indianapolis	252,098	19,995	8.61
Colorado, Denver	243,286	47,077	23.99
Missouri, Kansas City	212,580	7,080	3.45
Total, 14 plans	7,379,614	559,355	8.20
Percent to grand total	65.11	60.33	----------

See footnotes at end of table.

TABLE II.—*Blue Shield plans and other nonprofit plans listed by size, showing first quarter growth for 1949*—Continued

	Total membership	First-quarter growth	
		Members	Percent
100,000 to 200,000 members:			
Wisconsin, Milwaukee	*197, 380	13, 871	7. 56
North Carolina, Durham#[2]	176, 789	12, 779	7. 79
New Hampshire, Concord	174, 277	9, 052	5. 48
New York, Buffalo	*174, 200	14, 329	8. 96
Missouri, St. Louis	170, 511	16, 678	10. 84
Virginia, Richmond	169, 811	10, 592	6. 65
Texas, Dallas (group medical and surgical)	166, 007	16, 342	10. 92
Minnesota, St. Paul	*151, 711	51, 045	50. 71
Alabama, Birmingham	*151, 270	8, 933	6. 28
Delaware, Wilmington	144, 725	2, 548	1. 79
District of Columbia,	134, 913	24, 020	21. 66
British Columbia, Vancouver##	132, 334	6, 055	4. 79
Oklahoma, Tulsa	128, 936	9, 639	8. 08
Wisconsin, Madison	118, 920	16, 994	16. 67
Kansas, Topeka	118, 228	11, 748	11. 03
New York, Utica	115, 846	5, 857	5. 33
Oregon, Portland## (Oregon physicians service)	110, 997	1, 061	9. 65
Iowa, Des Moines	106, 612	19, 485	22. 36
Total, 18 plans	2, 643, 467	251, 028	10. 49
Percent to grand total	23. 32	27. 08	----------
50,000 to 100,000 members:			
Florida, Jacksonville	95, 676	14, 406	17. 72
Ohio, Cleveland #	94, 354	7, 165	8. 22
Montana, Helena	85, 071	6, 467	8. 23
Virginia, Roanoke	77, 940	6, 267	8. 74
New York, Rochester	77, 021	8, 368	12. 19
Nebraska, Omaha	73, 990	7, 199	10. 78
New York, Albany#	54, 957	3, 258	6. 30
Manitoba, Winnipeg##	52, 208	872	1. 70
Puerto Rico, San Juan	52, 110	1, 830	3. 64
West Virginia, Charleston	51, 607	1, 345	2. 68
Total, 10 plans	714, 934	57, 177	8. 69
Percent to grand total	6. 31	6. 17	----------
25,000 to 50,000 members:			
Louisiana, New Orleans# (hospital service of New Orleans)	49, 787	4, 622	10. 23
Illinois, Chicago	42, 109	22, 435	114. 03
West Virginia, Huntington [3]	38, 406	2, 824	7. 94
Oregon, Portland# (northwest hospital service)	37, 622	4, 716	14. 33
Arizona, Phoenix	36, 352	2, 876	8. 59
Utah, Salt Lake City	35, 414	(1, 074)	(2. 94)
New Brunswick, Moncton#	34, 062	11, 845	53. 31
Hawaii, Honolulu##	30, 219	331	1. 11
Mississippi, Jackson	28, 964	2, 022	7. 51
West Virginia, Wheeling	28, 769	412	1. 45
Ontario, Toronto#	26, 965	--------------	----------
Total, 12 plans	388, 669	51, 009	15. 11
Percent to grand total	3. 43	5. 50	----------
Less than 25,000 members:			
Louisiana, New Orleans (Louisiana physician service)	23, 956	(3, 270)	(12. 01)
West Virginia, Parkersburg	22, 403	646	2. 97
New York, Syracuse	21, 011	905	4. 50
West Virginia, Fairmont##	17, 443	37	. 21
Nevada, Reno**	16, 685	(124)	(. 74)
Idaho, Lewiston**	12, 586	40	. 32
New Mexico, Albuquerque#	12, 269	3, 444	39. 02
Wyoming, Cheyenne	10, 413	1, 460	16. 30
North Dakota, Fargo	9, 614	493	5. 41
Oregon, Eugene##	9, 529	--------------	----------
Tennessee, Memphis#	9, 492	4, 044	74. 22
Oregon, Klamath Falls##	*8, 682	(2, 228)	(20. 42)
Oregon, Coos Bay[4] ##	8, 103	--------------	----------
West Virginia, Clarksburg##	8, 064	300	3. 86

See footnotes at end of table.

TABLE II.—*Blue Shield plans and other nonprofit plans listed by size, showing first quarter growth for 1949*—Continued

	Total membership	First-quarter growth	
		Members	Percent
Less than 35,000 members:			
West Virginia:			
Bluefield	7,434	327	4.60
Morgantown##	2,553	282	12.42
Oregon, Oregon City## [4]	*2,500		
Texas, Dallas## (Dallas County medical plan)	2,228	96	4.50
Arkansas, Little Rock	2,109	2,109	
Total, 19 plans	207,074	8,561	4.31
Percent to grand total	1.83	.92	
Grand total, 73 plans	11,333,758	927,130	8.82

[1] 152,008 welfare members included in total membership.
[2] Includes hospital plan enrollment.
[3] Includes Ashland, Ky., plan enrollment.
[4] December 31 enrollment figures.
*Estimated.
**Nonmembers of Blue Shield not affiliated with Blue Cross.
Non-Blue Shield members operated by or affiliated with Blue Cross.
Blue Shield members not affiliated with Blue Cross.

TABLE III.—*Rate of growth of Blue Shield and non-Blue Shield plans divided between those affiliated and those not affiliated with Blue Cross, Mar. 31, 1949*

	Number of plans	Total membership	First-quarter growth	
			Members	Percent
Blue Shield plans:				
Affiliated with Blue Cross	47	9,379,680	773,563	8.99
Not affiliated with Blue Cross	12	384,860	6,806	1.80
Blue Shield total	59	9,764,540	780,369	8.69
Non-Blue Shield plans:				
Affiliated with Blue Cross	11	1,085,600	104,716	10.68
Not affiliated with Blue Cross	3	483,618	42,045	9.52
Non-Blue Shield total	14	1,569,218	146,761	10.32
Grand total	73	11,333,758	927,130	8.82

TABLE IV.—*Percentage of population enrolled in the United States, Territories, and Canadian provinces, Mar. 31, 1949*

State	Number of plans	Membership, Mar. 31, 1949	Estimated population July 1948	Percentage population enrolled Mar. 31, 1949
Delaware	1	144,725	297,000	48.72
Michigan	1	1,329,044	6,189,000	21.47
Colorado	1	243,286	1,151,000	21.14
New Hampshire, Vermont	1	174,277	919,000	18.96
Washington [1]	1	454,347	2,453,000	18.52
Montana	1	85,071	509,000	16.71
Massachusetts	1	765,538	4,704,000	16.27
District of Columbia, Washington, D. C	1	134,913	867,000	15.56
North Carolina	2	508,563	3,675,000	13.84
New York	6	1,737,685	14,357,000	12.11
Nevada	1	16,685	141,000	11.83
Oregon	6	177,433	1,625,000	10.92
California	2	1,037,391	9,894,000	10.48
Missouri	2	383,091	3,945,000	9.71
Wisconsin	2	316,300	3,307,000	9.57
West Virginia	8	166,731	1,915,000	8.64
Virginia	2	247,751	2,975,000	8.33

See footnote at end of table.

TABLE IV.—*Percentage of population enrolled in the United States, Territories, and Canadian provinces, Mar. 31, 1949*—Continued

State	Number of plans	Membership, Mar. 31, 1949	Estimated population July 1948	Percentage population enrolled Mar. 31,[1] 1949
Ohio	2	593, 657	7, 788, 000	7. 62
Indiana	1	252, 098	3, 907, 000	6. 45
Kansas	1	118, 228	1, 953, 000	6. 05
New Jersey	1	276, 913	4, 691, 000	5. 90
Nebraska	1	73, 990	1, 297, 000	5. 70
Arizona	1	36, 352	654, 000	5. 56
Oklahoma	1	128, 936	2, 352, 000	5. 48
Utah	1	35, 414	652, 000	5. 43
Alabama	1	151, 270	2, 839, 000	5. 33
Minnesota	1	151, 711	2, 938, 000	5. 16
Florida	1	95, 676	2, 320, 000	4. 12
Iowa	1	106, 612	2, 624, 000	4. 06
Wyoming	1	10, 413	270, 000	3. 86
Pennsylvania	1	400, 284	10, 676, 000	3. 75
Louisiana	2	73, 743	2, 566, 000	2. 87
Idaho	1	12, 586	530, 000	2. 37
Texas	2	168, 235	7, 153, 000	2. 35
New Mexico	1	12, 269	561, 000	2. 19
North Dakota	1	9, 614	559, 000	1. 72
Mississippi	1	28, 964	2, 112, 000	1. 37
Illinois	1	42, 109	8, 622, 000	. 49
Kentucky	1	9, 948	2, 793, 000	. 36
Tennessee	1	9, 492	3, 140, 000	. 30
Arkansas	1	2, 109	1, 923, 000	. 11
Total, 41 States and District of Columbia	66	10, 723, 454	133, 843, 000	8. 01
7 States			11, 447, 000	
Total, United States			145, 290, 000	7. 38
Hawaii	1	30, 219	[2] 502, 122	6. 02
Puerto Rico	1	52, 110	[3] 2, 141, 000	2. 43
Canada:				
British Columbia	1	132, 334	[4] 949, 000	13. 94
Quebec	1	282, 406	[4] 3, 561, 000	7. 71
Manitoba	1	52, 208	[4] 736, 000	7. 09
New Brunswick	1	34, 062	[4] 1, 181, 000	2. 88
Ontario	1	26, 965	[4] 4, 004, 000	. 67
5 Canadian Provinces	5	527, 975	10, 431, 000	5. 06
6 Canadian Provinces			1, 688, 000	
Total, Canada			12, 119, 000	4. 36
Grand total	73	11, 333, 758	159, 780, 377	7. 09

[1] Membership includes 152,008 welfare members.
[2] 1945 estimated population.
[3] 1941 estimated population.
[4] July 1945 estimated population.

TABLE V.—*Membership and growth, by districts, Mar. 31, 1949*

	Number of plans	Membership Mar. 31, 1949	Growth, first quarter	
			Members	Percent
District 1	2	939, 815	30, 303	3. 33
Districts 2 and 3	7	2, 014, 598	238, 709	13. 44
District 4	2	545, 009	49, 189	9. 92
District 5	14	1, 067, 906	94, 413	9. 70
District 6	8	413, 364	34, 696	9. 16
District 7	3	845, 755	61, 196	7. 80
District 8	2	1, 371, 153	39, 668	2. 98
District 9	10	1, 100, 810	116, 440	11. 83
District 10	6	658, 227	109, 087	19. 86
District 11	14	1, 849, 146	107, 192	6. 16
District 12	5	527, 975	46, 237	9. 60
Total	73	11, 333, 758	927, 130	8. 82

FINANCIAL REPORTS—BLUE SHIELD PLANS

For the Year 1948

(Tabulated by the Associated Medical Care Plans, the National Association of Blue Shield Plans)

Financial Experience of Blue Shield Plans December 31, 1948

(Including data of eight nonmember plans)

On December 31 there were 55 Blue Shield plans. Five new plans were accepted for membership, however, early in January. The new plans are designated as members in table I.

Three member plans did not report year-end financial data. The Arkansas plan is just beginning operation and had no data to submit. No reports were received from the plans at Eugene and Oregon City, Oreg.

In addition to the 57 reporting member plans 8 nonmember plans submitted financial reports which are included in the tables.

Two of the plans that reported did not submit balance sheet information.

Recapitulation table I indicates that total assets of the 63 plans equal $36,628,847. Reserves held by these plans is approximately half of this figure or $18,327,782. As shown in recapitulation table III these reserves are equal to $1.90 per member covered. The reserves-per-member figure is somewhat overstated since several plans, as indicated by footnotes, are reporting combined hospital and medical plan balance-sheet data.

As shown in recapitulation table II, total income for the year was $80,435,839, 77.58 percent ($62,404,422) was paid out in benefits and 8.55 percent ($6,873,940) was set aside for reserves. Operating expenses for the year amounted to $11,157,477, or 13.87 percent of income.

It is interesting to note that no plan in table I reported a deficit reserve figure. Only seven plans in table II have suffered operating losses during the year. The third-quarter report indicated that eight plans, at that time, were showing an operating deficit. All the seven plans showing operating losses, except two, show a smaller operating loss at the end of the year than was reported in the third quarter statement.

Table IV indicates that $3,564,401 was paid out in benefits under the veterans-care program during 1948.

Lynn Doctor,
Actuarial and Statistical Division.

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TABLE I.—*Dec. 31, 1948, balance sheet—information reported by 63 medical service plans*

RECAPITULATION

	Assets					Liabilities and reserves			Total liabilities
	Cash	Accounts and notes receivable	Investments	Prepaid expenses and other assets	Total assets	Accounts and notes payable	Deferred income	Reserves	
SECTION TOTALS									
Sec. 1	$7, 633, 193	$2, 663, 818	$12, 231, 693	$141, 851	$22, 670, 555	$6, 977, 207	$4, 193, 313	$11, 500, 035	$22, 670, 555
Sec. 2	3, 456, 216	1, 823, 047	4, 406, 589	55, 500	9, 741, 352	3, 157, 464	1, 835, 560	4, 748, 328	9, 741, 352
Sec. 3	961, 065	343, 422	889, 954	10, 095	2, 204, 536	817, 986	395, 514	991, 036	2, 204, 536
Sec. 4	510, 114	82, 643	807, 966	16, 700	1, 417, 423	395, 492	242, 905	779, 026	1, 417, 423
Sec. 5	401, 316	65, 841	127, 824		594, 981	178, 060	107, 564	309, 357	594, 981
Total, 63 plans	12, 961, 904	4, 978, 771	18, 464, 026	224, 146	36, 628, 847	11, 526, 209	6, 774, 856	18, 327, 782	36, 628, 847

PLANS LISTED BY SIZE ACCORDING TO MEMBERSHIP DATA

SEC. 1—200,000 OR MORE MEMBERS (11 PLANS)

PLAN HEADQUARTERS	Cash	Accounts and notes receivable	Investments	Prepaid expenses and other assets	Total assets	Accounts and notes payable	Deferred income	Reserves	Total liabilities
Detroit, Mich	$1, 819, 810	$219, 793	$1, 784, 343		$3, 823, 946	$1, 377, 059	$507, 819	$1, 939, 068	$3, 823, 946
New York, N. Y	1, 242, 154	406, 221	2, 429, 731		4, 078, 106	688, 842	769, 012	2, 620, 252	4, 078, 106
Boston, Mass	1, 424, 671	287, 568	1, 836, 227		3, 548, 466	1, 372, 067	349, 461	1, 826, 938	3, 548, 466
San Francisco, Calif.[1]	455, 538	729, 154	1, 635, 021	$111, 665	2, 931, 378	1, 440, 365	810, 881	680, 132	2, 931, 378
Columbus, Ohio	609, 091	44, 124	553, 851		1, 207, 066	267, 823	249, 601	689, 642	1, 207, 066
Harrisburg, Pa	309, 048	335, 724	363, 555	12, 636	1, 020, 963	297, 389	154, 386	569, 188	1, 020. 963
Chapel Hill, N. C.[1]	709, 711	22, 470	587, 913		1, 320, 094	425, 517	350, 862	543, 715	1, 320, 094
Oakland, Calif.[1 2]	387, 831	205, 555	2, 286, 906	17, 374	2, 897, 666	521, 545	691, 515	1, 684, 606	2, 897, 666
Newark, N. J	184, 908	158, 737	314, 655		658, 300	222, 365	62, 756	373, 179	658. 300
Indianapolis, Ind	299, 686	26, 227	350, 611	35	676, 559	152, 281	80, 611	443, 667	676, 559
Kansas City, Mo	190, 745	228, 245	88, 880	141	508, 011	211, 954	166, 409	129, 648	508, 011
Total, 11 plans	7, 633, 193	2, 663, 818	12, 231, 693	141, 851	22, 670, 555	6, 977, 207	4, 193, 313	11, 500, 035	22, 670, 555

SEC. 2—100,000 TO 200,000 MEMBERS (18 PLANS)

Denver, Colo	$96,797	$251,571			$348,368	$65,230	$115,929	$167,209	$348,368
Milwaukee, Wis	150,600	323,583	$302,677		776,860	79,986	192,244	504,630	776,860
Concord, N. H	124,383	199,421	169,174		492,978	245,542	91,171	156,265	492,978
Durham, N. C.[1 2]	270,527	8,045	526,451		805,023	223,195	228,300	353,528	805,023
Buffalo, N. Y	290,497	114,630	201,747		606,874	123,254	103,076	380,544	606,874
Richmond, Va	206,247	26,865	100,208		333,320	129,213	65,936	138,171	333,320
St. Louis, Mo	221,828	100,970	298,797		621,595	109,538	56,666	455,391	621,595
Dallas, Tex. (Group Medical and Surgical Service)	98,933	27,192	301,438	$196	427,759	70,041	41,866	315,852	427,759
Birmingham, Ala.[1]	442,953	1,276	915,094	10,470	1,369,793	212,382	328,888	828,523	1,369,793
Wilmington, Del.[1]	273,477	7,867	590,859	3,416	875,619	247,972	155,037	472,610	875,619
Vancouver, British Columbia [3]	240,145	9,427	96,987	34,312	380,871	259,648		121,223	380,871
Tulsa, Okla	144,150				144,150	29,861	27,889	86,400	144,150
Washington, D. C	64,872	227,615			292,487	79,861	84,467	128,159	292,487
Utica, N. Y	186,567	13,697	427,581		627,845	186,869	55,303	385,673	627,845
Portland, Oreg. (Oregon Physicians' Service)[1 3]	393,655	202,153	255,000	7,106	857,914	778,411	55,943	23,560	857,914
Topeka, Kans	5,123	76,164	190,576		271,863	92,298	102,304	77,261	271,863
Madison, Wis	109,039	146,410			255,449	88,122	75,522	91,805	255,449
St. Paul, Minn	136,423	86,161	30,000		252,584	136,041	55,019	61,524	252,584
Total, 18 plans	3,456,216	1,823,047	4,406,589	55,500	9,741,352	3,157,464	1,835,560	4,748,328	9,741,352

SEC. 3—50,000 TO 100,000 MEMBERS (11 PLANS)

Cleveland, Ohio [2]	$135,272	$7,825	$100,489		$243,586	$60,366	$30,865	$152,355	$243,586
Des Moines, Iowa	9,278	32,493	296,907	$2,245	340,923	109,081	70,647	161,195	340,923
Jacksonville, Fla	78,336	4,621	75,479		158,436	41,507	17,642	99,287	158,436
Helena, Mont	198,210	140,812	24,000	5,603	368,625	203,169	130,601	34,855	368,625
Roanoke, Va	10,623				10,623			10,623	10,623
Rochester, N. Y	87,690	41,379	140,885		269,954	76,466	35,360	158,128	269,954
Omaha, Nebr	80,615	5,906	124,873		211,394	50,034	61,193	100,167	211,394
Albany, N. Y.[2]	143,115	21,084	20,112		184,311	77,243	41,303	65,765	184,311
Winnipeg, Manitoba [3]	135,062	19,368	30,750	694	185,874	106,243	2,793	76,838	185,874
San Juan, P. R.[1]	29,302	38,177	109	1,553	69,141	51,202	5,110	12,829	69,141
Charleston, W. Va	53,562	31,757	76,350		161,669	42,675		118,994	161,669
Total, 11 plans	961,065	343,422	889,954	10,095	2,204,536	817,986	395,514	991,036	2,204,536

See footnotes at end of table.

TABLE I.—*Dec. 31, 1948, balance sheet—information reported by 63 medical service plans*—Continued

PLANS LISTED BY SIZE ACCORDING TO MEMBERSHIP DATA—Continued

SEC. 4—25,000 TO 50,000 MEMBERS (10 PLANS)

	Assets					Liabilities and reserves			Total liabilities
	Cash	Accounts and notes receivable	Investments	Prepaid expenses and other assets	Total assets	Accounts and notes payable	Deferred income	Reserves	
New Orleans, La. (Hospital Service of New Orleans)[2]	$14,769	$4,398	$120,630		$139,797	$29,934	$9,484	$100,379	$139,797
Salt Lake City, Utah	21,513	26,553	62,544	$452	111,062	37,914	23,969	49,179	111,062
Huntington, W. Va.[4]	34,760		10,000	131	44,891		15,118	29,773	44,891
Phoenix, Ariz	93,483	30,131	5,008		128,622	15,784	16,703	96,135	128,622
Portland, Oreg. (Northwestern Hospital Service)[1 2]	172.160	3,666	450,736	1,242	627,804	226,224	146,439	255,141	627,804
Honolulu, T. H.[1 3]	94,464	5,686	148,775	9,267	258,192	62,740	18,353	177,099	258,192
Wheeling, W. Va	41,225				41,225		5,912	35,313	41,225
New Orleans, La. (Louisiana Physicians Service)	18,194	10,045	5,217		33,456	14,000	3,845	15,611	33,456
Jackson, Miss	19,546	2,164	5,056	5,608	32,374	8,896	3,082	20,396	32,374
Total, 10 plans	510,114	82,643	807,966	16,700	1,417,423	395,492	242,905	779,026	1,417,423

SEC. 5—LESS THAN 25,000 MEMBERS (13 PLANS)

	Cash	Accounts and notes receivable	Investments	Prepaid expenses and other assets	Total assets	Accounts and notes payable	Deferred income	Reserves	Total liabilities
Parkersburg, W. Va	$12,404	$16,471			$28,875	$11,947	$8,243	$8,685	$28,875
Syracuse, N. Y	64,887	25,539	40,000		130,426	47,961	16,534	65,931	130,426
Chicago, Ill	45,364	6,859			52,223	13,528	28,634	10,061	52,223
Fairmont, W. Va.[3]	14,558	3,812	10,000		28,370	7,623	3,852	16,895	28,370
Lewiston, Idaho[1 5]	28,931		15,000		43,931	34,691		9,240	43,931
Klamath Falls, Oreg.[3]	(6)	(6)	(6)	(6)	(6)	(6)	(6)	(6)	(6)
Albuquerque, N. Mex.[3] (New Mexico Physicians Service)	(6)	(6)	(6)	(6)	(6)	(6)	(6)	(6)	(6)
Fargo, N. Dak	36,347				36,347	4,716	4,762	26,869	36,347
Cheyenne, Wyo	20,314	7,616			27,930	16,842	4,537	6,551	27,930
Coos Bay, Oreg.[3]	5,384		5,600		10,984	1,283		9,701	10,984
Clarksburg, W. Va.[3]	15,682	227			15,909	2,735	4,408	8,766	15,909
Bluefield, W. Va	43,865				43,865		1,014	42,851	43,865
Memphis, Tenn.[1 2]	104,111	3,003	50,224		157,338	33,934	34,380	89,024	157,338
Morgantown, W. Va.[3]	4,054	1,600			5,654	800	1,200	3,654	5,654
Dallas, Tex.[3] (Dallas County Medical Plan)	5,415	714	7,000		13,129	2,000		11,129	13,129
Total, 13 plans	401,316	65,841	127,824		594,981	178,060	107,564	309,357	594,981

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[1] Combined balance sheet data for hospital and medical plan.

[2] Nonmembers of Blue Shield operated by or affiliated with Blue Cross.

[3] Blue Shield members not affiliated with Blue Cross.

[4] Huntington, W. Va., figures include Ashland, Ky., plan.

[5] Nonmembers of Blue Shield not affiliated with Blue Cross.

[6] No balance-sheet data.

TABLE II.—*Operating statement information for the year 1948—65 plans reporting*

RECAPITULATION [1]

	Earned income	Total income	Medical and/or surgical expense		Operating expense		Net income	
			Amount	Percent	Amount	Percent	Amount	Percent
SECTION TOTALS								
Sec. 1	$49,923,221	$50,204,746	$38,609,770	76.91	$6,954,489	13.85	$4,640,487	9.24
Sec. 2	19,519,262	19,617,036	15,663,221	79.84	2,587,017	13.19	1,366,798	6.97
Sec. 3	5,224,435	5,295,700	4,074,024	76.93	779,406	14.72	442,270	8.35
Sec. 4	3,323,104	3,343,969	2,529,930	75.60	551,502	16.49	262,537	7.85
Sec. 5	1,953,276	1,974,388	1,527,477	77.36	285,063	14.44	161,848	8.20
Total, 65 plans	79,943,298	80,435,839	62,404,422	77.58	11,157,477	13.87	6,873,940	8.55
Total 55 Blue Shield plans in United States and Territories	69,839,984	70,256,321	54,050,596	76.94	10,085,778	14.35	6,119,947	8.71

SEC. 1—200,000 OR MORE MEMBERS (11 PLANS)

	Earned income	Total income	Medical and/or surgical expense		Operating expense		Net income	
			Amount	Percent	Amount	Percent	Amount	Percent
PLAN HEADQUARTERS								
Detroit, Mich	$7,856,360	$7,889,526	$6,504,745	82.45	$964,964	12.23	$419,817	5.32
New York, N. Y	6,618,730	6,663,061	4,390,731	65.90	1,398,535	20.99	873,795	13.11
Boston, Mass	6,698,652	6,728,464	5,313,232	78.97	684,507	10.17	730,725	10.86
San Francisco, Calif	12,815,090	12,926,215	10,065,533	77.87	1,932,260	14.95	928,422	7.18
Columbus, Ohio	2,713,338	2,723,613	1,913,864	70.27	394,989	14.50	414,760	15.23
Harrisburg, Pa	2,210,892	2,210,038	1,487,031	67.29	303,212	13.72	419,795	18.99
Chapel Hill, N. C	1,054,353	1,058,671	800,387	75.60	178,373	16.85	79,911	7.55
Oakland, Calif.[2]	5,439,640	5,476,813	4,548,620	83.05	438,158	8.00	490,035	8.95
Newark, N. J	1,524,815	1,528,191	1,203,652	78.76	228,913	14.98	95,626	6.26
Indianapolis, Ind	1,379,566	1,387,485	929,784	67.01	255,436	18.41	202,265	14.58
Kansas City, Mo	1,611,785	1,612,669	1,452,191	90.05	175.142	10.86	(14,664)	(.91)
Total, 11 plans	49,923,221	50,204,746	38,609,770	76.91	6,954,489	13.85	4,640,487	9.24

See footnotes at end of table.

TABLE II.—*Operating statement information for the year 1948—65 plans reporting*—Continued

RECAPITULATION[1]

SEC. 2—100,000 TO 200,000 MEMBERS (18 PLANS)

	Earned income	Total income	Medical and/or surgical expense		Operating expense		Net income	
			Amount	Percent	Amount	Percent	Amount	Percent
Denver, Colo.[3]	$2,089,345	$2,089,345	$1,708,392	81.77	$192,411	9.21	$188,542	9.02
Milwaukee, Wis.	1,509,576	1,512,238	1,021,790	67.57	192,997	12.76	297,451	19.67
Concord, N. H.	1,761,812	1,766,531	1,613,137	91.32	177,732	10.06	(24,338)	(1.38)
Durham, N. C.	630,278	630,278	403,187	63.97	140,942	22.36	86,149	13.67
Buffalo, N. Y.	979,634	984,410	686,731	69.77	100,212	10.17	197,467	20.06
Richmond, Va.	1,101,964	1,105,184	919,987	83.24	189,384	17.14	(4,187)	(.38)
St. Louis, Mo.	1,095,643	1,098,732	767,274	69.83	176,907	16.10	154,551	14.07
Dallas, Tex. (Group Medical and Surgical Service)	822,304	826,072	492,113	59.57	132,083	15.99	201,876	24.44
Birmingham, Ala.	857,753	857,753	832,610	97.06	128,161	14.95	(103,018)	(12.01)
Wilmington, Del.	1,026,587	1,026,587	954,783	93.01	98,657	9.61	(26,853)	(2.62)
Vancouver, British Columbia	576,929	577,079	582,372	100.92	42,044	7.28	(47,377)	(8.20)
Tulsa, Okla.	656,912	656,912	543,779	82.78	85,131	12.96	28,002	4.26
Washington, D. C.[3]	416,620	416,620	228,802	54.91	59,659	14.32	128,159	30.77
Utica, N. Y.	809,777	819,999	643,073	78.42	113,645	13.86	63,281	7.72
Portland, Oreg.[4] (Oregon Physicians' Service)	3,447,816	3,509,018	2,989,312	85.19	486,973	13.88	32,733	.93
Topeka, Kans.	742,230	745,284	596,222	80.00	118,371	15.88	30,691	4.12
Madison, Wis.	666,386	666,386	477,526	71.66	106,177	15.93	82,683	12.41
St. Paul, Minn.	328,008	328,608	202,131	61.51	45,531	13.86	80,946	24.63
Total, 18 plans	19,519,262	19,617,036	15,663,221	79.84	2,587,017	13.19	1,366,798	6.97

SEC. 3—50,000 TO 100,000 MEMBERS (11 PLANS)

	Earned income	Total income	Medical and/or surgical expense		Operating expense		Net income	
			Amount	Percent	Amount	Percent	Amount	Percent
Cleveland, Ohio	$493,803	$494,608	$395,334	79.93	$58,828	11.89	$40,446	8.18
Des Moines, Iowa	536,695	536,695	385,876	71.90	83,948	15.64	66,871	12.46
Jacksonville, Fla.	430,382	431,104	315,732	73.24	71,422	16.56	43,950	10.20
Helena, Mont.	829,112	882,526	649,173	73.56	187,482	21.24	45,871	5.20
Roanoke, Va.[3]	423,157	423,157	371,861	87.88	49,940	11.80	1,356	.32
Rochester, N. Y.	368,545	370,304	253,522	68.46	58,360	15.76	58,422	15.78
Omaha, Nebr.	519,061	519,998	379,296	72.94	82,825	15.93	57,877	11.13
Albany, N. Y.[2][3]	325,577	325,648	245,095	75.26	34,805	10.69	45,748	14.05
Winnipeg, Manitoba[2]	624,947	629,503	528,489	83.95	62,004	9.85	39,010	6.20
San Juan, P. R.[4]	369,147	377,569	320,888	84.99	55,017	14.57	1,664	.44
Charleston, W. Va.	303,528	304,588	228,758	75.10	34,775	11.42	41,055	13.48
Total, 11 plans	5,224,435	5,295,700	4,074,024	76.93	779,406	14.72	442,270	8.35

SEC. 4—25,000 TO 50,000 MEMBERS (10 PLANS)

New Orleans, La. (Hospital Service of New Orleans)	$278,659	$285,716	$210,020	73.51	$44,198	15.47	$31,498	11.02
Salt Lake City, Utah	304,636	306,475	252,634	82.43	50,291	16.41	3,550	1.16
Huntington, W. Va.[5]	206,441	206,616	153,832	74.45	33,397	16.16	19,387	9.39
Phoenix, Ariz	175,467	175,663	59,297	33.76	21,497	12.24	94,869	54.00
Portland, Oreg.[4] (Northwest Hospital Service)	1,231,999	1,241,210	1,040,679	83.84	165,952	13.37	34,579	2.79
Honolulu, T. H.[4]	646,321	648,458	469,567	72.41	143,051	22.06	35,840	5.53
Wheeling, W. Va	183,640	183,640	151,388	82.43	25,192	13.72	7,060	3.85
New Orleans, La.[3] (Louisiana Physicians' Service)	211,085	211,225	152,709	72.30	43,158	20.43	15,358	7.27
Jackson, Miss	84,856	84,966	39,804	46.85	24,766	29.15	20,396	24.00
Total, 10 plans	3,323,104	3,343,969	2,529,930	75.66	551,502	16.49	262,537	7.85

SEC. 5—LESS THAN 25,000 MEMBERS (15 PLANS)

Parkersburg, W. Va.[3]	$169,194	$169,194	$140,180	82.85	$15,698	9.28	$13,316	7.87
Syracuse, N. Y	197,407	197,907	150,240	75.92	24,501	12.38	23,166	11.70
Chicago, Ill	69,068	69,068	46,579	67.44	37,428	54.19	(14,939)	(21.63)
Fairmont, W. Va	111,318	111,318	100,291	90.09	8,586	7.72	2,441	2.19
Lewiston, Idaho [2] [4]	224,506	229,660	182,469	79.45	26,904	11.71	20,287	8.84
Klamath Falls, Oreg.[4]	299,317	299,317	201,945	67.47	38,257	12.78	59,115	19.75
Albuquerque, N. Mex. (New Mexico Physician Service)	84,853	84,853	63,892	75.30	15,908	18.75	5,053	5.95
Fargo, N. Dak.[3]	59,591	60,461	44,664	73.87	11,736	19.41	4,061	6.72
Cheyenne, Wyo.[3]	31,061	31,061	16,855	54.26	7,655	24.65	6,551	21.09
Coos Bay, Oreg.[4]	287,508	290,044	263,764	90.94	22,691	7.82	3,589	1.24
Clarksburg, W. Va.[3]	64,063	64,063	52,733	82.32	6,857	10.70	4,473	6.98
Bluefield, W. Va	51,037	51,037	24,324	47.66	7,686	15.06	19,027	37.28
Memphis, Tenn.[4]	276,976	289,003	217,561		57,864		13,578	
Morgantown, W. Va	16,377	16,377	13,142	80.25	2,020	12.33	1,215	7.42
Dallas, Tex. (Dallas County Medical Plan)	11,000	11,025	8,838	80.17	1,272	11.53	915	8.30
Total, 15 plans	1,953,276	1,974,388	1,527,477	77.36	285,063	14.44	161,848	8.20

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[1] Does not include data for Blue Shield plans at Eugene and Oregon City, Oreg.

[2] Earned income not reported.

[3] Payments to physicians does not include an estimate for unreported cases.

[4] Combined operating statement data for hospital and medical plan.

[5] Huntington, W. Va., figures include Ashland, Ky., plan.

TABLE III.—*Reserve ratios per member*

RECAPITULATION

	Total membership	Reserves	Reserves per member
Sec. 1	5, 956, 891	$11, 500, 035	$1. 93
Sec. 2	2, 501, 521	4, 748, 328	1. 90
Sec. 3	744, 884	991, 036	1. 33
Sec. 4	296, 033	779, 026	2. 63
Sec. 5	142, 388	309, 357	2. 17
Total 63 plans	9, 641, 717	18, 327, 782	1. 90

SEC. 1—200,000 OR MORE MEMBERS (11 PLANS)

PLAN HEADQUARTERS			
Detroit, Mich	1, 311, 811	$1, 939, 068	$1. 48
New York, N. Y	1, 128, 967	2, 620, 252	2. 32
Boston, Mass	[1] 744, 287	1, 826, 938	2. 45
San Francisco, Calif.[2]	699, 998	680, 132	. 97
Columbus, Ohio	465, 267	689, 642	1. 48
Harrisburg, Pa	353, 643	569, 188	1. 61
Chapel Hill, N. C.[2]	297, 192	543, 715	1. 83
Oakland, Calif.[2]	281, 519	1, 684, 606	5. 98
Newark, N. J	236, 604	373, 179	1. 58
Indianapolis, Ind	232, 103	443, 667	1. 91
Kansas City, Mo	205, 500	129, 648	. 63
Total, 11 plans	5, 956, 891	11, 500, 035	1. 93

SEC. 2—100,000 TO 200,000 MEMBERS (18 PLANS)

Denver, Colo	196, 209	$167, 209	$0. 85
Milwaukee, Wis	183, 509	504, 630	2. 75
Concord, N. H	165, 225	156, 265	. 95
Durham, N. C.[2]	[3] 164, 010	353, 528	2. 16
Buffalo, N. Y	[1] 159, 871	380, 544	2. 38
Richmond, Va	159, 219	138, 171	. 87
St. Louis, Mo	153, 833	455, 391	2. 96
Dallas, Tex. (group medical and surgical service)	149, 665	315, 852	2. 11
Birmingham, Ala.[2]	142, 337	828, 523	5. 82
Wilmington, Del.[2]	142, 177	472, 610	3. 32
Vancouver, British Columbia	126, 279	121, 223	. 96
Tulsa, Okla	119, 297	86, 400	. 72
Washington, D. C	[1] 110, 893	128, 159	1. 16
Utica, N. Y	109, 989	385, 673	3. 51
Portland, Oreg. (Oregon Physicians' Service)[2]	109, 936	23, 560	. 21
Topeka, Kans	106, 480	77, 261	. 73
Madison, Wis	101, 926	91, 805	. 90
St. Paul, Minn	[1] 100, 666	61, 524	. 61
Total, 18 plans	2, 501, 521	4, 748, 328	1. 90

SEC. 3—50,000 TO 100,000 MEMBERS (11 PLANS)

Cleveland, Ohio	87, 189	$152, 355	$1. 75
Des Moines, Iowa	87, 127	161, 195	1. 85
Jacksonville, Fla	81, 270	99, 287	1. 22
Helena, Mont	78, 604	34, 855	. 44
Roanoke, Va	71, 673	10, 623	. 15
Rochester, N. Y	68, 653	158, 128	2. 30
Omaha, Nebr	66, 791	100, 167	1. 50
Albany, N. Y	51, 699	65, 765	1. 27
Winnipeg, Manitoba	51, 336	76, 838	1. 50
San Juan, P. R. [2]	50, 280	12, 829	. 25
Charleston, W. Va	50, 262	118, 994	2. 37
Total, 11 plans	744, 884	991, 036	1. 33

See footnotes at end of table.

TABLE III—*Reserve ratios per member*—Continued

RECAPITULATION

SEC. 4—25,000 TO 50,000 MEMBERS (10 PLANS)

	Total membership	Reserves	Reserves per member
New Orleans, La. (Hospital Service of New Orleans)	[1] 45,165	$100,379	$2.22
Salt Lake City, Utah	36,488	49,179	1.35
Huntington, W. Va	35,585	29,773	.84
Phoenix, Ariz	33,476	96,135	2.87
Portland, Oreg. [2] (Northwest Hospital Service)	32,906	255,141	7.75
Honolulu, T. H. [2]	29,888	177,099	5.93
Wheeling, W. Va	28,357	35,313	1.25
New Orleans, La. (Louisiana Physicians' Service)	27,226	15,611	.57
Jackson, Miss	26,942	20,396	.76
Total, 10 plans	296,033	779,026	2.63

SEC. 5—LESS THAN 25,000 MEMBERS (13 PLANS)

	Total membership	Reserves	Reserves per member
Parkersburg, W. Va	21,757	$8,685	$0.40
Syracuse, N. Y	20,106	65,931	3.28
Chicago, Ill	19,674	10,061	.51
Fairmont, W. Va	17,406	16,895	.97
Lewiston, Idaho [2]	[1] [4] 12,546	9,240	.74
Klamath Falls, Oreg	---	---	---
Albuquerque, N. Mex. (New Mexico Physicians' Service)	---	---	---
Fargo, N. Dak	[1] 9,121	26,869	2.95
Cheyenne, Wyo	8,953	6,551	.73
Coos Bay, Oreg	8,103	9,701	1.20
Clarksburg, W. Va	7,764	8.766	1.13
Bluefield, W. Va	7,107	42,851	6.03
Memphis, Tenn.[2]	5,448	89,024	16.34
Morgantown, W. Va	2,271	3,654	1.61
Dallas, Tex. (Dallas County Medical Plan)	2,132	11,129	5.22
Total, 13 plans	142,388	309,357	2.17

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[1] Estimate.
[2] Combined data for hospital and medical plan.
[3] Includes hospital enrollment.
[4] Includes 601 welfare members.

TABLE IV.—*Veterans' care program*

	Fees earned	Payments to physicians	Operating expense	Net income or (loss)
Detroit, Mich	$1,139,671	$1,031,898	$97,579	$10,194
San Francisco, Calif.[1]	1,734,559	1,734,559	350,474	0
Chapel Hill, N. C	145,472	134,690	10,996	(214)
Denver, Colo	107,607	101,066	7,869	(1,328)
Portland, Oreg. (Oregon Physican's Service)	93,253	86,613	(2)	(2)
Helena, Mont	134,488	122,392	11,814	282
Des Moines, Iowa	310,158	285,160	23,388	1,610
Honolulu, Hawaii	74,822	68,023	6,455	344
Total eight plans	3,740,030	3,564,401	508,575	10,888

[1] VA reimburses California for actual expenses incurred.
[2] Not reported.

Veterans' programs not reported—Washington.

DIRECTORY OF BLUE SHIELD PLANS

(Associated Medical Care Plans, the National Association of Blue Shield Plans)

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NONPROFIT PLANS NOT MEMBERS OF ASSOCIATED MEDICAL CARE PLANS

Hospital Service of California, 360 Fourteenth Street, Oakland 4, Calif.
Connecticut Medical Service, 152 Temple Street, New Haven, Conn.
North Idaho District Medical Service Bureau, 222 Carssow Building, Lewiston, Idaho.
Hospital Service of New Orleans, American Bank Building, New Orleans, La.
Nevada State Medical Association Program, P. O. Box 966, 118 Califorina Avenue, Reno, Nex.
Surgical Service, Inc., 1001 West Tijeras Street, Albuquerque, N. Mex.
Northeastern New York Medical Service, Inc., 112 State Street, Albany, N. Y.
Hospital Care Association, Inc., 107 Market Street, Durham, N. C.
Cleveland Hospital Service, Inc., 2060 East Ninth Street, Cleveland, Ohio.
North West Hospital Service, 1320 Southwest Broadway, Portland, Oreg.
Memphis Hospital Service, Sterick Building, Memphis, Tenn.
Washington State Medical Bureau, 338 White-Henry-Stuart Building, Seattle 1, Wash.

BLUE SHIELD PLANS

Alabama:
  Hospital Service Corp. of Alabama, 2119 First Avenue North, Birmingham 3, Ala.: H. F. Singleton, manager; A. C. Jackson, M. D., president; Clyde L. Sibley, secretary.

Arizona:
  Arizona's Blue Shield Plan, 202 Arizona Title Building, Phoenix, Ariz.: L. Donald Lau, executive director; E. Payne Palmer, M. D., president; C. C. Craig, M. D., secretary.

Arkansas:
  Arkansas Medical and Hospital Service, Inc., 815 Rector Building, Little Rock, Ark.: J. L. Redheffer, executive director; Ellery C. Gay, M. D., president; John A. Rowland, secretary.

California:
  California Physicians' Service, 450 Mission Street, San Francisco 5, Calif.: W. M. Bowman, executive director; Lowell S. Goin, M. D., president; Chester L. Cooley, M. D., secretary.

Colorado:
  Colorado Medical Service, Inc., 1653 Lawrence Street, Denver 2, Colo.: Joseph R. Grant, executive director; Atha Thomas, M. D., president; George R. Buck, M. D., secretary.

Delaware:
  Group Hospital Service, Inc., 902 Orange Street, Wilmington 99, Del.: H. V. Maybee, managing director; F. A. Wardenburg, president; W. Edwin Bird, M. D., secretary.

District of Columbia:
  Medical Service of District of Columbia, 825 Seventeenth Street NW., Washington 6, D. C.: F. P. Rawlings, Jr., director; F. D. Costenbader, M. D., president; Theodore Wiprud, secretary.

Florida:
  Florida Medical Service Corp., P. O. Box 1798, Jacksonville 1, Fla.: H. A. Schroder, executive director; Leigh F. Robinson, M. D., president; Herbert White, M. D., secretary.

Illinois:
  Chicago Medical Service, 425 North Michigan Avenue, Chicago 11, Ill.: E. P. Lichty, executive director; Rollo K. Packard, M. D., president; Frederick W. Slobe, M. D., secretary.
  Rock Island County Medical Service, Moline, Ill.
  Northern Illinois Hospital Service, 227 North Wyman Street, Rockford, Ill.

Indiana:
  Mutual Medical Insurance, Inc., 700 Test Building, Indianapolis 4, Ind.; R. S. Saylor, executive vice president; W. U. Kennedy, M. D., president; Walter L. Portteus, M. D., secretary.

Iowa:

Iowa Medical Service, 324 Liberty Building, Des Moines 9, Iowa; Wilbur R. Quinn, executive director; Martin I. Olsen, M. D., president; W. F. Poorman, secretary.

Kansas:

Kansas Physicians' Service, 601 Topeka Boulevard, Topeka, Kans.; Sam J. Barham, executive director; Conrad M. Barnes, M. D., president; Dwight Lawson, M. D., secretary-Treasurer.

Kentucky:

Medical Service, Inc., Second National Bank Building, Ashland, Ky.: Kentucky Physicians Service, 120 South Fourth Street, Louisville, Ky.; J. H. Mathewson, executive director; E. W. Garred, M. D., president; J. H. Mathewson, secretary (plan operated out of Huntington, W. Va.).

Louisiana:

Louisiana Physicians Service, Inc., 1430 Tulane Avenue, New Orleans 13, La.: Frank Lais, Jr., executive director; O. B. Owens, M. D., president; H. Whitney Boggs, M. D., secretary.

Massachusetts:

Massachusetts Medical Service, 38 Chauncy Street, Boston 11, Mass.: C. G. Hayden, M. D., executive director; James C. McCann, M. D., president; Edmond L. Twomey, treasurer and clerk.

Michigan:

Michigan Medical Service, Washington Boulevard Building, Detroit 26, Mich.: Jay C. Ketchum, executive vice president; Robert L. Novy, M. D., president; P. L. Ledwidge, M. D., secretary.

Minnesota:

Minnesota Medical Service, 2388 University Avenue, St. Paul 4, Minn.: Arthur M. Calvin, executive director; Olof I. Sohlberg, M. D., president; C. A. McKinlay, M. D., secretary.

Mississippi:

Mississippi Hospital & Medical Service, 420 Yazoo Street, P. O. Box 1043, Jackson, Miss.: Richard C. Williams, executive director; W. W. Hollowell, president.

Missouri:

Surgical-Medical Care, 1021 McGee Street, Kansas City 6, Mo.; F. K. Helsby, director; Ira H. Lockwood, M. D., president; F. L. Feierabend, M. D., secretary.

Missouri Medical Service, 3615 Olive Street, St. Louis 8, Mo.: Carl F. Vohs, M. D., president; Raymond O. Muether, M. D., secretary.

Montana:

Montana Physicians' Service, Power Block, Helena, Mont.: Samuel English, executive director; M. A. Shillington, M. D., president; T. L. Hawkins, M. D., secretary.

Nebraska:

Nebraska Medical Service, 518 Kilpatrick Building, Omaha 2, Nebr.: J. H. Pfeiffer, executive director; A. J. Offerman, M. D., president; E. K. McDermott, secretary.

New Hampshire:

New Hampshire-Vermont Physicians Service, 6 Odd Fellows Avenue, Concord, N. H.: R. S. Spaulding, executive director; Leslie K. Sycamore, M. D., president; Frank J. Sulloway, clerk.

New Jersey:

Medical-Surgical Plan of New Jersey, 31 Clinton Street, Newark 2, N. J.: N. M. Scott, M. D., medical director; Thomas K. Lewis, M. D., president; John S. Thompson, secretary-treasurer.

New York:

Western New York Medical Plan, Inc., 888 Delaware Avenue, Buffalo, N. Y.: C. M. Metzger, executive director; Carlton E. Wertz, M. D., president; Joseph C. O'Gorman, M. D., secretary.

United Medical Service, Inc., 80 Lexington Avenue, New York 16, N. Y.: John F. McCormack, executive vice president; Charles G. Heyd, M. D., president; DeWitt Stetten, M. D., secretary.

Genesee Valley Medical Care, Inc., 41 Chestnut Street, Rochester 4, N. Y.: Sherman D. Meech, technical adviser; M. A. Barnard, M. D., president; D. M. Jenkins, M. D., secretary.

Central New York Medical Plan, 407 South State Street, Syracuse 2, N. Y.: J. Campbell Butler, executive director; Leo E. Gibson, M. D., president; Frederic N. Marty, M. D., secretary.

New York—Continued
- Medical and Surgical Care, Inc., 5 Hopper Street, Utica, N. Y.: H. C. Stephenson, managing director; F. M. Miller, Jr., M. D., president; Michael Yust, secretary.

North Carolina:
- Hospital Saving Association of North Carolina, Chapel Hill, N. C.: E. B. Crawford, executive vice president; Robert Lassiter, president; J. Lyman Melvin, secretary-treasurer.

North Dakota:
- North Dakota Physicians Service, 114½ Roberts Street, Fargo, N. Dak.: D. E. Eagles, executive director; O. A. Sedlak, M. D., president; V. G. Borland, M. D., secretary-treasurer.

Ohio:
- Ohio Medical Indemnity, Inc., Hartman Theater Building, Columbus 15, Ohio; C. H. Coghlan, executive vice president; L. Howard Schriver, M. D., president; Charles S. Nelson, secretary-treasurer.

Oklahoma:
- Oklahoma Physicians' Service, 315 South Denver Street, Tulsa 3, Okla.: N. D. Helland, executive director; Glen Leslie, president; Joe N. Hamilton, secretary.

Oregon:
- Coos Bay Hospital Association, 218 Hall Building. Coos Bay, Oreg.: T. J. Kingsley, manager; Bernard Barkwill, M. D., president; R. M. McKeown, M. D.. secretary-treasurer.
- Pacific Hospital Association, Miner Building, Eugene. Oreg.: C. F. Wright, manager; M. S. Jones, M. D., president; D. C. Stanand, M. D., secretary-treasurer.
- Klamath Medical Service Bureau, 405 Pine Street, Klamath Falls, Oreg.: L. A. Brown, manager; C. V. Rugh, M. D., president; P. W. Sharp, M. D., secretary.
- Physicians Association of Clackamas County, Barclay Building, Oregon City, Oreg.: Mrs. M. G. French, manager; W. O. Steele, M. D., president; R. L. Strickland. M. D., secretary.
- Oregon Physicians' Service. 1214 South West Sixth Avenue. Portland 4, Oreg.: W. C. Marshall, general manager; D. R. Ross, M. D., president; C. I. Drummond, M. D., secretary.

Pennsylvania:
- Medical Service Association of Pennsylvania, 222 Locust Street, Harrisburg, Pa.: D. T. Diller, executive director; J. A. Daugherty, M. D., president; Lester H. Perry, secretary.

South Carolina:
- *South Carolina Medical Care Plan, Greenville, S. C.

Tennessee:
- Tennessee Hospital Service Association, Dome Building. Chattanooga, Tenn.

Texas:
- Dallas County Medical Plan, 433 Medical Arts Building, Dallas 1, Tex.: M. J. Heath, executive director; J. Howard Shane, M. D.. president; Charles D. Bussey, M. D., secretary-treasurer.
- Group Medical & Surgical Service, 2208 Main Street, Dallas 1, Tex.: W. R. McBee, executive director; E. H. Cary, M. D., president; Lawrence Payne, secretary.

Utah:
- Medical Service Bureau of Utah State Medical Association, 42 South Fifth East, Salt Lake City 2, Utah: Allen H. Tibbals, executive director; Sol G. Kahn, M. D.. president; W. LeRoy Smith, M. D., treasurer.

Vermont: See New Hampshire.

Virginia:
- Surgical Care, Inc., Colonial-American National Bank Building, Roanoke, Va.: L. O. Key, executive director; W. L. Powell, M. D.. president.
- Virginia Medical Service Association, 207 East Franklin Street, Richmond 19, Va.: M. Haskins Coleman, Jr., director; Waverly R. Payne, M. D., president; Carson L. Fifer, M. D., secretary-treasurer.

West Virginia:
- Surgical Service, Inc., 404 Bland Street, Bluefield. W. Va.: W. A. McCue, secretary; Charles M. Scott, M. D.. president.
- Medical Service, Inc., Atlas Building, Charleston, W. Va.: John Hart, managing director; John E. Cannaday, M. D.. president; John Hart, secretary.

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*Indicates associate member.

West Virginia—Continued
- Medical-Surgical Service, Inc., Empire Bank Building, Clarksburg, W. Va.: S. H. Beauchamp, treasurer-manager; James E. Wilson, M. D., president; Chesney M. Carney, secretary.
- Marion County Medical Service, Inc., 201 Masonic Building, Fairmont, W. Va.: L. Mason Brooks, manager; J. R. Tuckwiller, M. D., president; Harrison Conaway, secretary.
- Medical Care, Inc., Sixth Avenue at Eleventh Street, Huntington 9, W. Va.: J. H. Mathewson, executive director; Herman M. Brown, president; J. H. Mathewson, treasurer-secretary.
- *Medical-Surgical Service, Inc., 265 High Street, Morgantown, W. Va.: Ward D. Stone, executive director; Eldon B. Tuckner, M. D., president; Ward D. Stone, secretary-treasurer.
- Medical-Surgical Care, Inc., 202 Union Trust Building, Parkersburg, W. Va.: R. A. Wyland, executive director; A. R. Lutz, M. D., president; F. L. Davis, secretary.
- West Virginia Medical Service, Inc., National Exchange Bank Building, Wheeling, W. Va.: W. M. Morel, secretary-director; D. A. MacGregor, M. D., president.

Wisconsin:
- Wisconsin Physicians Service, 704 East Gorham Street, Madison 3, Wis.: R. F. Weber, executive director; C. O. Vingom, M. D., chairman.
- Surgical Care, 208 East Wisconsin Avenue, Milwaukee 2, Wis.: James O. Kelley, executive secretary; A. H. Luthmers, director; L. J. Van Hecke, M. D., president; (Surgical Care is not incorporated but operated as an agency of the Medical Society of Milwaukee County).

Wyoming:
- *Wyoming Medical Service, Box 1252, Cheyenne, Wyo.: Arthur R. Abbey, executive director; G. W. Koford, M. D., president; Byron Hirst, secretary.

Hawaii:
- Hawaii Medical Service Association, 1160 Bishop Street, Honolulu 9, Hawaii: O. B. Patterson, executive director; Richard Kimball, president; Joseph Palma, M. D., secretary.

Puerto Rico:
- Puerto Rico Hospital Service Association, Ochoa Building, San Juan, Puerto Rico: Arturo La Cruz, executive director; Manuel de La Pila, M. D., president; Walter Rivera, M. D., secretary.

Canada:
- *Medical Services Association, 423 West Broadway, Vancouver, British Columbia: A. L. McLellan, director and secretary; G. L. Watson, M. D., director of medical services; C. P. Chaston, president.
- *Manitoba Medical Service, 149 Portage Avenue, East, Winnipeg, Manitoba: A. G. Richardson, executive director; G. Lawson, chairman; S. A. Boyd, M. D., secretary.

(*) Indicates associate member.

Blue Shield Commission

	Trustee representative	Executive representative
District 1	Leslie K. Sycamore, M. D., Hanover, N. H	Charles G. Hayden, M. D., Boston.
District 2	Frederic E. Elliott, M. D., United Medical Service, 80 Lexington Avenue, New York 16, N. Y.	John F. McCormack, New York.
District 3	Carlton E. Wertz, M. D., 91 Parker Avenue, Buffalo 14, N. Y.	Norman M. Scott, M. D., Newark.
District 4	J. A. Daugherty, M. D., 610 North Third Street, Harrisburg, Pa.	H. V. Maybee, Wilmington.
District 5	W. L. Powell, M. D., Medical Arts Building, Roanoke, Va.	E. B. Crawford, Chapel Hill.
District 6	O. B. Owens, M. D., 1026 Bolton Avenue, Alexandria, La.	H. A. Schroder, Jacksonville.
District 7	L. Howard Schriver, M. D., 604 Doctors' Building, Cincinnati 2, Ohio.	R. S. Saylor, Indianapolis.
District 8	Robert L. Novy, M. D., 858 Fisher Building, Detroit 2, Mich.	Jay C. Ketchum, Detroit.
District 9	F. L. Feierabend, M. D., 327 Argyle Building, Kansas City 6, Mo.	W. R. McBee, Dallas.
District 10	A. J. Offerman, M. D., 4826 South Twenty-fourth Street, Omaha 7, Nebr.	James O. Kelley, Milwaukee.
District 11	C. L. Cooley, M. D., 490 Post Street, San Francisco 2, Calif.	W. C. Marshall, Portland.
District 12 (at large)	Walter L. Portteus, M. D., Franklin, Ind	N. D. Holland, Tulsa.

Representatives from the Council on Medical Service of the American Medical Association:
A. W. Adson, M. D., 102 Second Avenue SW., Rochester, Minn.
Elmer Hess, M. D., 8 East Twelfth Street, Erie, Pa.
Charles G. Heyd, M. D., 116 East Fifty-third Street, New York 22, N. Y.
J. D. McCarthy, M. D., 1036 Medical Arts Building, Omaha 2, Nebr.
Carl F. Vohs, M. D., 508 North Grand Boulevard, St. Louis, Mo.
(One member not yet appointed January 15, 1949.)
Legal counsel to the commission:
Howard Hassard, Peart, Baraty & Hassard, 111 Sutter Street, San Francisco 4, Calif.
Officers of the commission:
L. Howard Schriver, M. D., president.
Robert L. Novy, M. D., vice president.
Norman M. Scott, M. D., secretary.
Jay C. Ketchum, treasurer.

(NOTE.—With the exception of Dr. Elliott, addresses given for trustee commissioners are office rather than plan.)

BLUE SHIELD STAFF MEMBERS

Paul R. Hawley, M. D., chief executive officer.
Frank E. Smith, director.
Lydia W. Wright, secretary.
Betty B. Horton, secretary.
W. Rulon Williamson, the actuary.
Lynn A. Doctor, actuarial and statistical division.
John W. Castellucci, field assistant.
Aldine Bradley, clerical.

BLUE SHIELD COMMITTEES

Joint executive:
L. Howard Schriver, M. D.
F. L. Feierabend, M. D.
Jay C. Ketchum.
Executive:
L. Howard Schriver, M. D., president.
Robert L. Novy, M. D., vice president.
Norman M. Scott, M. D., secretary.
Jay C. Ketchum, treasurer.
F. L. Feierabend, M. D.
Charles G. Hayden, M. D.
Elmer Hess, M. D.
Resolutions:
Robert L. Novy, M. D., chairman.
Carlton E. Wertz, M. D.
Willard C. Marshall.
Leslie K. Sycamore, M. D.
Membership:
A. J. Offerman, M. D., chairman.
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John F. McCormack.
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Finance:
Jay C. Ketchum, chairman.
W. R. McBee.
Walter L. Portteus, M. D.
W. L. Powell, M. D.
Actuarial and statistical:
H. A. Schroder, chairman.
N. D. Helland.
H. V. Maybee.
John D. O'Brien.
George P. Farrell.
Public relations:
C. L. Cooley, M. D., chairman.
James O. Kelley.
Susan S. Jenkins.
Louis M. Connor.
Mark McIntyre.
Physician relations:
J. A. Daugherty, M. D., chairman.
O. B. Owens, M. D.
Charles Gordon Heyd, M. D.
A. W. Adson, M. D.
Charles H. Coghlan.
L. T. Reed.
Case procedure:
Charles G. Hayden, M. D., chairman.
William Gardenier, M. D.
G. P. McArdle, M. D.
T. L. Williams, M. D.
W. Edwin Bird, M. D.
Veterans care:
A E. Larsen, M. D., chairman.
E. B. Crawford.
Wilbur R. Quinn.
Samuel English.
Robert L. Novy, M. D.
John J. Vance.

(NOTE.—Howard Hassard, legal counsel, appointed ex officio member of joint executive, executive, and resolutions committees, and any other which may require his services.)

ENROLLMENT REPORTS—BLUE SHIELD PLANS

For the Year 1948

(Tabulated by the Associated Medical Care Plans, the National Association of Blue Shield Plans)

Blue Shield Enrollment December 31, 1948

(Including data of 12 nonmember plans)

As of December 31, 1948, there were 55 Blue Shield plans, the same number reported in the third-quarter enrollment report. However, at the commission meeting in January five plans were accepted for membership. The plan in Oregon City, Oreg., was reinstated, and the following plans were accepted as new members: Little Rock, Ark.; Syracuse, N. Y.; San Juan, P. R.; and Klamath Falls, Oreg.

All of these plans are reported as Blue Shield plans in the accompanying tables for a total of 60 Blue Shield plans, although 5 of them were not actually members on December 31. Arkansas is reported only in table I since it had no enrollment at the end of 1948.

Enrollment for the 72 nonprofit plans listed in table I is now past the 10,000,000 mark, 10,367,464. Blue Shield enrollment accounts for 8,995,021 members.

The enrollment growth during the fourth quarter and for the year is shown in table II. Fourth-quarter growth was 1,053,919 members (11.32 percent). Total members added during the year were 3,130,038, an increase in membership of 43.25 percent.

Several plans made outstanding gains during the fourth quarter and the year.

Michigan, by enrolling the Ford Motor Co., added 253,317 members in the fourth quarter for a total membership gain for the year of 376,280.

New York City added 99,135 members in the fourth quarter. Growth for the year was 398,674 members, the largest annual gain of any medical-service plan.

Blue Shield in California added 82,477 members in the fourth quarter.

Ohio, Pennsylvania, and Washington, D. C., all added more than 100,000 members during the year 1948.

Table III presents some interesting growth figures for Blue Shield and non-Blue Shield plans broken down between those affiliated and those not affiliated with Blue Cross. The table appears to indicate that either affiliation with Blue Shield or Blue Cross is conducive to healthy growth.

Table IV shows the percentage of the population enrolled in the various States compared with the corresponding percentage on December 31, 1947. Plans are now in operation in 40 States and the District of Columbia, covering 7.47 percent of the population in those areas; 6.78 percent of the total United States population is now enrolled.

Table V, showing membership and enrollment growth by district, is presented for the first time.

Lynn Doctor,
Actuarial and Statistical Division.

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Table I.—*Membership data of Blue Shield plans and other nonprofit plans, listed alphabetically by States, Dec. 31, 1949*

Plan headquarters	Subscribers	Dependents	Total membership	Members per contract
Alabama, Birmingham	64, 321	78, 016	142, 337	2. 21
Arizona, Phoenix	11, 746	21, 730	33, 476	2. 85
California:				
Oakland [1]	130, 706	150, 813	281, 519	2. 15
San Francisco	358, 400	341, 598	699, 998	1. 95
Colorado, Denver	77, 092	119, 117	196, 209	2. 55
Delaware, Wilmington	58, 622	83, 555	142, 177	2. 43
Florida, Jacksonville	34, 930	46, 340	81, 270	2. 33
Idaho, Lewiston [2]	5, 727	6, 218	[3] [4] 12, 546	2. 19
Illinois, Chicago	10, 578	9, 096	19, 674	1. 86
Indiana, Indianapolis	89, 987	142, 116	232, 103	2. 58
Iowa, Des Moines	39, 131	47, 996	87, 127	2. 23
Kansas, Topeka	39, 712	66, 768	106, 480	2. 68

See footnotes at end of table.

TABLE I.—*Membership data of Blue Shield plans and other nonprofit plans, listed alphabetically by States, Dec. 31, 1949*—Continued

Plan headquarters	Subscribers	Dependents	Total membership	Members per contract
Louisiana:				
New Orleans (Louisiana Physicians Service)	9,691	17,535	27,226	2.81
New Orleans (Hospital Service of New Orleans) [1]	[3] 19,301	[3] 25,864	[3] 45,165	2.34
Massachusetts, Boston	330,794	[3] 413,493	[3] 744,287	2.25
Michigan, Detroit	528,673	783,138	1,311,811	2.48
Minnesota, St. Paul	[3] 39,477	[3] 61,189	[3] 100,666	2.55
Mississippi, Jackson	11,733	15,209	26,942	2.30
Missouri:				
Kansas City	92,606	112,894	205,500	2.22
St. Louis	74,946	78,887	153,833	2.05
Montana, Helena	31,553	47,051	78,604	2.49
Nebraska, Omaha	27,946	38,845	66,791	2.39
Nevada, Reno [2] [5]	--------	--------	15,977	--------
New Hampshire, Concord	73,886	91,339	165,225	2.24
New Jersey, Newark	97,964	138,640	236,604	2.42
New Mexico:				
Albuquerque (New Mexico Physicians Service) [6]	[3] 3,650	[3] 7,200	[3] 10,850	2.97
Albuquerque (Surgical Service, Inc.) [1] [5]	3,294	5,531	8,825	2.68
New York:				
Albany [1]	22,146	29,553	51,699	2.33
Buffalo	62,793	[3] 97,078	[3] 159,871	2.57
New York	566,534	562,433	1,128,967	1.99
Rochester	29,131	39,522	68,653	2.36
Syracuse	8,342	11,764	20,106	2.41
Utica	52,582	57,407	109,989	2.09
North Carolina:				
Chapel Hill	120,751	176,441	297.192	2.46
Durham [1] [7]	69,697	94,313	164,010	2.35
North Dakota, Fargo	3,294	[3] 5,827	[3] 9,121	2.77
Ohio:				
Cleveland [1]	38,338	48,851	87,189	2.27
Columbus	191,371	273,896	465,267	2.43
Oklahoma, Tulsa	45,530	73,767	119,297	2.62
Oregon:				
Coos Bay [6]	7,862	241	8,103	1.03
Eugene [6]	7,850	1,679	9,529	1.21
Klamath Falls [6]	[3] 7,210	[3] 3,700	[3] 10,910	1.51
Oregon City [6]	--------	--------	[3] 2,500	--------
Portland (Northwest Hospital Service)[1]	15,349	17,557	32,906	2.14
Portland (Oregon Physicians Service)[6]	82,566	27,370	109,936	1.33
Pennsylvania, Harrisburg	163,256	190,387	353,643	2.17
Tennessee, Memphis [1]	2,157	3,291	5,448	2.53
Texas:				
Dallas (Dallas County Medical Plan)[6]	1,895	237	2,132	1.13
Dallas (Group Medical and Surgical)	57,496	92,169	149,665	2.60
Utah, Salt Lake City	13,243	23,245	36,488	2.76
Virginia:				
Richmond	68,786	90,433	159,219	2.31
Roanoke	26,556	45,117	71,673	2.70
Washington, Seattle [2] [8]	[3] 165,352	[3] 106,866	[3] 412,218	2.49
West Virginia:				
Bluefield	2,870	4,237	7,107	2.48
Charleston	18,184	32,078	50,262	2.76
Clarksburg [6]	3,138	4,626	7,764	2.47
Fairmont [6]	5,965	11,441	17,406	2.92
Huntington [9]	12,727	22,855	35,582	2.80
Morgantown [6]	952	1,319	2,271	2.39
Parkersburg	8,167	13,590	21,757	2.66
Wheeling	12,248	16,109	28,357	2.32
Wisconsin:				
Madison	43,189	58,737	101,926	2.36
Milwaukee	79,786	103,723	183,509	2.30
Wyoming, Cheyenne	3,316	5,637	8,953	2.70
District of Columbia, Washington, D. C	[3] 52,477	[3] 58,416	[3] 110,893	2.11
Hawaii, Honolulu [6]	15,399	14,489	29,888	1.94
British Columbia, Vancouver [6]	51,998	74,281	126,279	2.43
Manitoba, Winnipeg [6]	22,117	29,219	51,336	2.32
Quebec, Montreal [1]	[3] 113,677	[3] 141,264	[3] 254,941	2.24
Puerto Rico, San Juan	22,061	28,219	50,280	2.28
Total, 72 plans	4,564,824	5,643,562	10,367,464	2.27
60 Blue Shield plans	3,979,080	5,013.441	8,995,021	2.26

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[1] Nonmembers of Blue Shield operated by or affiliated with Blue Cross.
[2] Nonmembers of Blue Shield not affiliated with Blue Cross.
[3] Estimated.
[4] Includes 601 welfare members not shown under subscribers or dependents.
[5] September 30 enrollment data.
[6] Blue Shield members not affiliated with Blue Cross.
[7] Includes hospital enrollment.
[8] Includes 140,000 welfare members not shown under subscribers or dependents.
[9] Includes Ashland, Ky., enrollment figures, which plan operates from Huntington office.

TABLE II.—*Blue Shield plans and other nonprofit plans listed by size, showing annual and 4th quarter growth for 1948*

	Total membership	Growth, fourth quarter 1948		Growth for year 1948	
		Members	Percent	Members	Percent
200,000 or more members:					
Michigan, Detroit	1,311,811	253,317	23.93	376,280	40.22
New York, New York	1,128,967	99,135	9.63	398,674	54.59
Massachusetts, Boston	[1]744,287	21,067	2.91	18,768	2.59
California, San Francisco	699,998	82,477	13.35	181,207	34.92
Ohio, Columbus	465,267	48,493	11.63	170,116	57.63
Washington, Seattle [2][3]	[1]412,218	7,486	1.85	40,000	10.75
Pennsylvania, Harrisburg	353,643	59,213	20.11	223,263	171.24
North Carolina, Chapel Hill	297,192	14,568	5.15	58,343	24.43
California, Oakland [4]	281,519	21,980	8.47	79,494	39.35
Quebec, Montreal [4]	[1]254,941	20,841	8.90	93,069	57.50
New Jersey, Newark	236,604	26,628	12.68	92,904	64.65
Indiana, Indianapolis	232,103	27,525	13.45	90,810	64.27
Missouri, Kansas City	205,500	6,662	3.35	38,477	23.04
Total 13 plans	6,624,050	689,392	11.62	1,861,405	39.08
Percent grand total	63.90	65.41		59.47	
100,000 to 200,000 members:					
Colorado, Denver	196,209	(756)	(.38)	(23,081)	(10.53)
Wisconsin, Milwaukee	183,509	17,938	10.83	47,882	35.30
New Hampshire, Concord	165,225	901	.55	12,222	7.99
North Carolina, Durham [4][5]	164,010	4,555	2.86	41,033	33.37
New York, Buffalo	[1]159,871	15,855	11.01	40,163	33.55
Virginia, Richmond	159,219	12,818	8.76	44,444	38.72
Missouri, St. Louis	153,833	17,140	12.54	57,636	59.91
Texas, Dallas (Group Medicine and Surgery)	149,665	24,359	19.44	75,280	101.21
Alabama, Birmingham	142,337	11,051	8.42	43,866	44.54
Delaware, Wilmington	142,177	4,703	3.42	16,516	13.14
British Columbia, Vancouver [6]	126,279	2,333	1.88	28,570	29.23
Oklahoma, Tulsa	119,297	12,249	11.44	55,636	87.39
District of Columbia, Washington	[1]110,893	14,711	16.29	110,893	
New York, Utica	109,989	4,821	4.58	20,620	23.07
Oregon, Portland [6] (Oregon Physicians Service)	109,936	3,856	3.64	34,738	46.20
Kansas, Topeka	106,480	8,300	8.45	53,276	100.13
Wisconsin, Madison	101,926	20,896	25.78	54,222	113.66
Minnesota, St. Paul	[1]100,666	49,373	96.25	99,462	8,260.90
Total 18 plans	2,501,521	225,103	9.89	813,378	48.18
Percent grand total	24.13	21.36		25.99	
50,000 to 100,000 members:					
Ohio, Cleveland [4]	87,189	5,862	7.21	15,077	20.90
Iowa, Des Moines	87,127	20,016	29.82	50,203	135.96
Florida, Jacksonville	81,270	13,643	20.17	44,868	123.25
Montana, Helena	78,604	8,666	12.39	29,458	59.93
Virginia, Roanoke	71,673	2,735	3.97	15,908	28.52
New York, Rochester	68,653	8,662	14.44	22,888	49.60
Nebraska, Omaha	66,791	6,250	10.32	22,344	50.27
New York, Albany [4]	51,699	8,727	20.31	28,921	126.96
Manitoba, Winnipeg [6]	51,336	2,920	6.03	12,044	30.65
Puerto Rico, San Juan	50,280	5,837	13.13	7,167	16.62
West Virginia, Charleston	50,262	4,435	9.68	12,107	31.73
Total 11 plans	744,884	87,753	13.35	260,985	53.93
Percent grand total	7.18	8.32		8.34	
25,000 to 50,000 members:					
Louisiana, New Orleans [4] (Hospital Service of New Orleans)	[1]45,165	3,353	8.02	14,647	47.99
Utah, Salt Lake City	36.488	(2,180)	(5.63)	4,836	15.28
West Virginia, Huntington [7]	35,582	2,174	6.51	21,972	161.40
Arizona, Phoenix	33,476	7,116	27.00	31,962	2,111.10
Oregon, Portland [4] (Northwest Hospital Service)	32,906	3,995	13.82	11,991	57.33
Hawaii, Honolulu [6]	29,888	4.684	18.58	9,772	48.58
West Virginia, Wheeling	28,357	2,207	8.44	5,254	22.74
Louisiana, New Orleans (Louisiana Physicians Service)	27,226	688	2.59	6,875	33.78
Mississippi, Jackson	26,942	5,845	26.68	26,942	
Total 10 plans	296,030	27,882	10.40	134,251	82.98
Percent grand total	2.85	2.65		4.29	

See footnotes at end of table.

Table II.—*Blue Shield plans and other nonprofit plans listed by size, showing annual and 4th quarter growth for 1948*—Continued

	Total membership	Growth, fourth quarter 1948		Growth for year 1948	
		Members	Percent	Members	Percent
Less than 25,000 members:					
West Virginia, Parkersburg	21,757	2,325	11.96	3,099	16.61
New York, Syracuse	20,106	759	3.92	4,784	31.22
Illinois, Chicago	19,674	6,941	54.51	19,674	--------
West Virginia, Fairmont [6]	17,406	19	.11	2,820	19.33
Nevada, Reno [3] [8]	15,977	--------	--------	5,683	55.21
Idaho, Lewiston [3] [9]	[1] 12,546	1,556	14.16	5,692	83.04
Oregon, Klamath Falls [6]	[1] 10,910	(1,600)	(12.79)	(6,075)	(35.77)
New Mexico, Albuquerque [6] (New Mexico Physicians Service)	[1] 10,850	2,150	24.71	3,389	45.42
Oregon, Eugene [6]	9,529	383	4.18	1,879	24.57
North Dakota, Fargo	[1] 9,121	2,097	29.85	1,042	12.90
Wyoming, Cheyenne	8,953	3,135	53.88	8,953	--------
New Mexico, Albuquerque [4] [8] (Surgical Service, Inc.)	8,825	--------	--------	--------	--------
Oregon, Coos Bay [6]	8,103	380	4.92	877	12.14
West Virginia, Clarksburg [6]	7,764	199	2.63	493	5.32
West Virginia, Bluefield	7,107	(82)	(1.14)	1,694	31.29
Tennessee, Memphis [4]	5,448	5,448	--------	5,448	--------
Oregon, Oregon City [6]	[1] 2,500	0	0	0	0
West Virginia, Morgantown [6]	2,271	69	3.13	471	26.17
Texas, Dallas [6] (Dallas County Medical Plan)	2,132	10	.47	96	4.71
Total 19 plans	200,979	23,789	13.43	60,019	42.58
Percent grand total	1.94	2.26	--------	1.91	--------
Grand total 71 plans	10,367,464	1,053,919	11.32	3,130,038	43.25

[1] Estimated.
[2] 140,000 welfare members included in total membership.
[3] Nonmembers of Blue Shield not affiliated with Blue Cross.
[4] Non-Blue Shield members operated by or affiliated with Blue Cross.
[5] Includes hospital enrollment.
[6] Blue Shield members not affiliated with Blue Cross.
[7] Includes Kentucky plan enrollment.
[8] September 30, 1948 enrollment.
[9] 601 welfare members included in total membership.

Table III.—*Rate of growth of Blue Shield and non-Blue Shield plans, divided between those affiliated and those not affiliated with Blue Cross, Dec. 31, 1948*

	Number of plans	Total membership	Growth, fourth quarter, 1948		Growth for year 1948	
			Members	Percent	Members	Percent
Blue Shield plans:						
Affiliated with Blue Cross	46	8,606,117	954,713	12.48	2,699,909	45.71
Not affiliated with Blue Cross	13	388,904	15,403	4.12	89,074	29.71
Blue Shield total	59	8,995,021	970,116	12.09	2,788,983	44.94
Non-Blue Shield plans:						
Affiliated with Blue Cross	9	931,702	74,761	8.72	289,680	45.12
Not affiliated with Blue Cross	3	440,741	9,042	2.09	51,375	13.19
Non-Blue Shield total	12	1,372,443	83,803	6.50	341,055	33.07
Grand total	71	10,367,464	1,053,919	11.32	3,130,038	43.25

TABLE IV.—*Percentage of population enrolled in the United States, Territories, and Canadian provinces, Dec. 31, 1948*

State	Number of plans	Membership. Dec. 31, 1948	Estimated population, July, 1948	Percentage of population enrolled Dec. 31, 1948	Percentage of population enrolled Dec. 31, 1947	Percentage gain in 1948
Delaware	1	142,177	297,000	47.87	42.90	4.97
Michigan	1	1,311,811	6,189,000	21.20	14.97	6.23
New Hampshire-Vermont	1	165,225	[1] 919,000	17.97	16.80	1.17
Colorado	1	196,209	1,151,000	17.05	18.92	(1.87)
Washington [2]	1	[1] 412,218	2,453,000	16.80	17.32	(.52)
Massachusetts	1	[1] 744,287	4,704,000	15.82	[1] 15.35	(.47)
Montana	1	78,604	509,000	15.44	9.95	5.49
District of Columbia	1	[1] 110,893	867,000	12.79	--------	12.79
North Carolina	2	461,202	3,675,000	12.55	[1] 10.76	1.79
Nevada	1	15,977	141,000	11.33	7.35	3.98
New York	6	[1] 1,539,285	14,357,000	10.72	[1] 7.23	3.49
Oregon	6	[1] 173,884	1,625,000	10.70	[1] 8.59	2.11
California	2	981,517	9,894,000	9.92	7.85	2.07
Missouri	2	359,333	3,945,000	9.11	6.83	2.28
Wisconsin	2	285,435	3,307,000	8.63	[1] 5.61	3.02
West Virginia	8	161,421	1,915,000	8.43	6.34	2.09
Virginia	2	230,892	2,975,000	7.76	5.65	2.11
Ohio	2	552,456	7,788,000	7.09	4.72	2.37
Indiana	1	232,103	3,907,000	5.94	3.66	2.28
Utah	1	36,488	652,000	5.60	4.97	.63
Kansas	1	106,480	1,953,000	5.45	2.78	2.67
Nebraska	1	66,791	1,297,000	5.15	3.42	1.73
Arizona	1	33,476	654,000	5.12	.23	4.89
Oklahoma	1	119,297	2,352,000	5.07	2.75	2.32
New Jersey	1	236,604	4,691,000	5.04	3.24	1.80
Alabama	1	142,337	2,839,000	5.01	3.49	1.52
Florida	1	81,270	2,320,000	3.50	1.52	1.98
New Mexico	2	[1] 19,675	561,000	3.50	1.66	1.84
Minnesota	1	[1] 100,666	2,938,000	3.43	.04	3.39
Wyoming	1	8,953	270,000	3.32	--------	3.32
Iowa	1	87,127	2,624,000	3.32	1.42	1.90
Pennsylvania	1	353,643	10,676,000	3.31	1.27	2.04
Louisiana	2	[1] 72,391	2,566,000	2.82	2.00	.82
Idaho [3]	1	[1] 12,546	530,000	2.37	1.40	.97
Texas	2	151,797	7,153,000	2.12	1.07	1.05
North Dakota	1	[1] 9,121	559,000	1.63	1.46	.17
Mississippi	1	26,942	2,112,000	1.28	--------	1.28
Kentucky	1	9,085	2,793,000	.33	--------	.33
Illinois	1	19,674	8,622,000	.23	--------	.23
Tennessee	1	5,448	3,140,000	.17	--------	.17
Total, 40 States and District of Columbia	66	9,854,740	131,920,000	7.47	6.21	[4] 1.26
8 States	--------	--------	13,370,000	--------	--------	--------
Total United States	--------	--------	145,290,000	6.78	4.86	1.92
Hawaii	1	29,888	[5] 502,122	5.95	4.01	1.94
Puerto Rico	1	50,280	[6] 1,869,255	2.69	2.31	.38
Canada:						
British Columbia	1	126,279	[7] 949,000	13.30	10.30	3.00
Manitoba	1	51,336	[7] 736,000	6.98	5.34	1.64
Quebec	1	[1] 254,941	[7] 3,561,000	7.16	4.55	2.61
3 Canadian Provinces	3	432,556	5,246,000	8.25	5.70	2.55
8 Canadian Provinces	--------	--------	6,873,000	--------	--------	--------
Total Canada	3	432,556	12,119,000	3.57	2.47	1.10
Grand total	71	10,367,464	159,780,377	6.49	4.64	1.85

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[1] Estimated.

[2] Membership includes 100,000 welfare members.

[3] Membership includes 601 welfare members.

[4] 34 States.

[5] 1945 estimated population.

[6] 1941 estimated population.

[7] July 1945 estimated population.

TABLE V.—*Membership, growth, and percent of population enrolled by districts, Dec. 31, 1948*

	Number of plans	Membership, Dec. 31, 1948	Growth, fourth quarter, 1948		Growth for year, 1948		Percent of population enrolled
			Members	Percent	Members	Percent	
District 1	2	909, 512	21, 968	2. 48	30, 990	3. 53	16. 17
Districts 2 and 3	7	1, 775, 889	164, 587	10. 21	608, 954	52. 18	9. 32
District 4	2	495, 820	63, 916	14. 80	239, 779	93. 65	4. 51
District 5	14	973, 493	60, 733	6. 65	318, 531	48. 63	7. 96
District 6	7	378, 668	45, 865	13. 78	149, 813	65. 46	2. 55
District 7	3	784, 559	81, 880	11. 65	276, 003	54. 27	6. 71
District 8	2	1, 331, 485	260, 258	24. 30	395, 954	42. 32	8. 99
District 9	11	995, 220	80, 365	8. 78	301, 624	43. 49	5. 52
District 10	6	549, 140	116, 570	26. 95	275, 155	100. 43	5. 07
District 11	14	1, 741, 122	131, 683	8. 18	399, 552	29. 78	10. 68
District 12	3	432, 556	26, 094	6. 42	133, 683	44. 73	8. 25
Total	71	10, 367, 464	1, 053, 919	11. 32	3, 130, 038	43. 25	1. 85

Subsequently Dr. Hawley provided Senator Murray with similar data relative to Blue Cross as distinct from Blue Shield plans. The material appears below.

Blue Cross enrollment, United States and Territories, as of Mar. 31, 1949

State	Plan, headquarters, city	Enrollment Mar. 31, 1949	State population [1]	Percent of State population enrolled in plan	Total percent of State population enrolled
Alabama	Birmingham	[2] 243, 322	2, 839, 000	[2] 8. 57	[2] 8. 57
Arizona	Phoenix	102, 117	654, 000	15. 61	15. 61
Arkansas	Little Rock	2, 475	1, 923, 000	. 13	. 13
California	----------	992, 689	9, 894, 000	----------	10. 03
	Los Angeles	605, 121	----------	6. 12	----------
	Oakland	387, 568	----------	3. 91	----------
Colorado	Denver	429, 260	1, 151, 000	37. 29	37. 29
Connecticut	New Haven	874, 293	2, 008, 000	43. 54	43. 54
Delaware	Wilmington	161, 049	297, 000	54. 23	54. 23
District of Columbia	Washington	387, 894	867, 000	44. 74	44. 74
Florida	Jacksonville	173, 327	2, 320, 000	7. 47	7. 47
Georgia	----------	[2] 117, 008	3, 104, 000	----------	[2] 3. 77
	Atlanta	70, 201	----------	2. 26	----------
	Columbus	[2] 19, 969	----------	[2]. 64	----------
	Savannah	26, 838	----------	. 87	----------
Idaho	Boise	56. 601	530, 000	10. 68	10. 68
Illinois	----------	1, 993, 621	8, 622, 000	----------	23. 12
	Alton	124, 633	----------	1. 45	----------
	Chicago	1, 589, 238	----------	18. 43	----------
	Rockford	279, 750	----------	3. 24	----------
Indiana	Indianapolis	383, 377	3, 907, 000	9. 81	9. 81
Iowa and South Dakota	----------	583, 199	3, 244, 000	----------	17. 98
	Des Moines	495, 407	----------	15. 27	----------
	Sioux City	87, 792	----------	2. 71	----------
Kansas	Topeka	331, 829	1, 953, 000	16. 99	16. 99
Kentucky	Louisville	251, 562	2, 793, 000	9. 01	9. 01
Louisiana	----------	214, 586	2, 566, 000	----------	8. 36
	Alexandria	58, 717	----------	2. 29	----------
	New Orleans	155, 869	----------	6. 07	----------
Maine	Portland	[2] 234, 241	897, 000	[2] 26. 11	[2] 26. 11
Maryland	Baltimore	617, 096	2, 118, 000	29. 14	29. 14
Massachusetts	Boston	[2] 1, 787, 414	4, 704, 000	[2] 38. 00	[2] 38. 00
Michigan	Detroit	1, 547, 469	6, 189, 000	25. 00	25. 00
Minnesota	St. Paul	[2] 915, 238	2, 938, 000	[2] 31. 15	[2] 31. 15
Mississippi	Jackson	32, 215	2, 112, 000	1. 53	1. 53
Missouri	----------	1, 155, 048	3, 945, 000	----------	29. 28
	St. Louis	897, 981	----------	22. 76	----------
	Kansas City	257, 067	----------	6. 52	----------
Montana	Helena	106, 827	509, 000	20. 99	20. 99
Nebraska	Omaha	121, 860	1, 297, 000	9. 40	9. 40
New Hampshire and Vermont	Concord	229. 637	919, 000	24. 99	24. 99
New Jersey	Newark	1, 341, 959	4, 691, 000	28. 61	28. 61
New Mexico	Albuquerque	16, 010	561, 000	2. 85	2. 85

See footnotes at end of table.

Blue Cross enrollment, United States and Territories, as of Mar. 31, 1949—Con.

State	Plan, headquarters, city	Enrollment Mar. 31, 1949	State population [1]	Percent of State population enrolled in plan	Total percent of State population enrolled
New York		[2] 5,495,940	14,357,000		[2] 38.28
	Albany	263,064		1.83	
	Buffalo	[2] 485,024		[2] 3.38	
	Jamestown	33,474		.23	
	New York	3,894,567		27.13	
	Rochester	354,343		2.47	
	Syracuse	284,649		1.98	
	Utica	161,820		1.13	
	Watertown	18,999		.13	
North Carolina		577,522	3,675,000		15.71
	Chapel Hill	400,733		10.90	
	Durham	176,789		4.81	
North Dakota	Fargo	[2] 62,709	559,000	[2] 11.22	[2] 11.22
Ohio		[2] 2,841,825	7,788,000		[2] 36.49
	Akron	199,617		2.56	
	Canton	[2] 132,898		[2] 1.71	
	Cincinnati	758,456		9.74	
	Cleveland	914,545		11.74	
	Columbus	[2] 258,772		[2] 3.32	
	Lima	71,463		.92	
	Portsmouth	28,703		.37	
	Toledo	[2] 299,703		[2] 3.85	
	Youngstown	[2] 177,668		[2] 2.28	
Oklahoma	Tulsa	278,890	2,352,000	11.86	11.86
Oregon	Portland	67,589	1,625,000	4.16	4.16
Pennsylvania		[2] 3,615,005	10,676,000		[2] 33.86
	Allentown	205,821		1.93	
	Harrisburg	[2] 420,620		[2] 3.94	
	Philadelphia	1,383,414		12.96	
	Pittsburgh	1,318,339		12.35	
	Wilkes-Barre	286,811		2.68	
Rhode Island	Providence	537,614	742,000	72.45	72.45
South Carolina	Greenville	68,271	1,960,000	3.48	3.48
Tennessee		362,543	3,140,000		11.55
	Chattanooga	272,846		8.69	
	Kingsport	52,935		1.69	
	Memphis	36,762		1.17	
Texas	Dallas	437,184	7,153,000	6.11	6.11
Utah	Salt Lake City	95,124	652,000	14.59	14.59
Virginia		414,190	2,975,000		13.92
	Lynchburg	10,404		.35	
	Newport News	23,229		.78	
	Norfolk	48,178		1.62	
	Richmond	240,993		8.10	
	Roanoke	91,386		3.07	
Washington	Seattle	[2] 107,766	2,453,000	[2] 4.39	[2] 4.39
West Virginia		219,160	1,915,000		11.44
	Bluefield	19,219		1.00	
	Charleston	71,107		3.71	
	Huntington	63,271		3.30	
	Parkersburg	32,119		1.68	
	Wheeling	33,444		1.75	
Wisconsin	Milwaukee	708,551	3,307,000	21.43	21.43
Wyoming	Cheyenne	42,012	270,000	15.56	15.56
Total United States served by Blue Cross.		31,335,118	145,151,000		21.59
Puerto Rico	San Juan	52,110	[3] 2,141,000		2.43
Total United States and Puerto Rico served by Blue Cross.		31,387,228	147,292,000		21.31
Not served by Blue Cross—Nevada			141,000		
Total		31,387,228	147,433,000		21.29

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[1] Population, July 1, 1948.

[2] Estimate.

[3] Population, July 1, 1947.

Sec. A. Balance sheet data—Tables 1 to 5, reported as of Dec. 31, 1948, by 90 plans to the Blue Cross Commission

RECAPITULATION OF SECTION A

Sec. A	Assets				
	Cash	Accounts, notes receivable	Investments	Prepaid expenses and other assets	Total assets
Table 1, 17 plans	$22,058,021	$3,058,927	$80,549,192	$292,058	$105,958,198
Table 2, 28 plans	11,295,518	1,362,884	22,293,490	97,956	35,049,848
Table 3, 16 plans	2,881,984	390,385	5,089,916	25,090	8,387,375
Table 4, 14 plans	1,259,192	154,162	1,430,281	13,382	2,857,017
Table 5, 15 plans	578,603	44,509	555.702	10.361	1,189,175
Total, 90 plans	38,073,318	5,010,867	109,918,581	438,847	153,441,613

Sec. A	Liabilities and reserves			
	Accounts notes payable	Deferred income	Reserves	Total liabilities, reserves
Table 1, 17 plans	$27,313,433	$21,127,048	$57,517,717	$105,958,198
Table 2, 28 plans	10,132,944	8,876,227	16.040,677	35,049.848
Table 3, 16 plans	2,114,548	1,950,648	4,322,179	8,387,375
Table 4, 14 plans	691,593	847,281	1,318,143	2,857,017
Table 5, 15 plans	231,671	303.000	654,504	1,189.175
Total, 90 plans	40,484,189	33.104,204	79,853,220	153,441,613

Sec. B. Operating statement—Tables 1 to 5—For the 12 months period ending Dec. 31, 1948, as reported by 90 plans to the Blue Cross Commission

RECAPITULATION OF SEC. B

Sec. B	Number of participants Dec. 31, 1948	Total income	Hospital expense		Operating expense		Net income	
			Amount	Percent	Amount	Percent	Amount	Percent
Table 1, 17 plans	20,371,879	$208,197,252	$177,789,752	85.39	$18,733,290	9.00	$11,674,210	5.61
Table 2, 28 plans	8,951,024	77,498,346	66,513,348	85.83	8,479,175	10.94	2,505,823	3.23
Table 3, 16 plans	2,284,794	20,865,903	17,660,392	84.64	2,231,742	10.70	973,769	4.66
Table 4, 14 plans	905,013	7,546,631	6,282.929	83.25	984,115	13.04	279,587	3.71
Table 5, 15 plans	408,502	3,364,898	2,681,702	79.70	428,883	12.75	254,313	7.55
Total 90 plans	32,921,212	317,473,030	270,928,123	85.34	30,857,205	9.72	15,687,702	4.94

FINANCIAL EXPERIENCE OF BLUE CROSS PLANS, 1948

SPECIAL STUDY NO. 111

The total admitted assets of the 90 Blue Cross plans as of December 31, 1948, amounted to $153,441,613, an increase of $28,670,480 (22.98 percent) over the assets reported as of December 31, 1947. Plan assets were composed of: cash, $38,073,318 (24.81 percent); accounts and notes receivable, $5,010,867 (3.27 percent); investments, $109,918,581 (71.64 percent); and prepaid expenses and other assets, $438,847 (.28 percent). All asset items except investments decreased percentagewise in relation to total assets at the end of 1948 compared to the distribution at the end of 1947. No decrease reached 1 percent. Investments increased 1.25 percent.

Accounts and notes payable amounted to $40,484,189 (26.39 percent); unearned subscriber payments, $33,104,204 (21.57 percent); and reserves, $79,853,220 (52.04 percent).

Plan reserves increased $11,790,474 over what they were as of December 31, 1947.

The total income for all Blue Cross plans for the year 1948 was $317,473,030, exceeding the 1947 total income by $70,574,718 (28.58 percent). The total payment for care to members (hospitalization) amounted to $270,928,123, 85.34 percent of the total income and exceeded the amount paid in 1947 by $59,535,238 (28.16 percent).

Operating expenses of the 90 plans required $30,857,205, 9.72 percent of their total income. This ratio of operating expense to total income is the lowest in Blue Cross history.

After deducting hospitalization and operational expenses from total income, the plans had a net income of $15,687,702, 4.92 percent of total income. The net income for 1948 was $7,675,116 more than in 1947 (95.79 percent).

	Number of plans	Total income	Hospital expense		Operating expense		Net income	
			Amount	Percent	Amount	Percent	Amount	Percent
1941	64	$46,319,310	$32,664,181	70.52	$5,691,672	12.29	$7,963,457	17.19
1942	66	61,876,730	46,183,857	74.64	7,527,656	12.17	8,165,217	13.19
1943	76	76,938,603	58,211,862	75.66	9,540,842	12.40	9,185,899	11.94
1944	73	96,935,236	73,883,961	76.22	11,922,200	12.30	11,129,075	11.48
1945	86	128,737,659	104,759,043	81.37	15,818,079	12.29	8,160,537	6.34
1946	87	171,673,168	171,354,949	82.34	22,326,775	13.01	7,991,444	4.65
1947	90	246,898,312	211,392,885	85.62	27,492,841	11.14	8,012,586	3.24
1948	90	317,473,030	270,928,123	85.34	30,857,205	9.72	15,687,702	4.94

As of December 31, 1948, the total reserves of the 90 approved Blue Cross plans were equivalent to 3.54 months of average monthly hospital expense and 3.02 months of average monthly income. Both of these ratios are below the recommendations of the National Association of Insurance Commissioners, which states that reserves should be equal to five times average monthly subscription income or seven times average monthly hospital expense, whichever is greater.

The reapproval standards for Blue Cross plans recommend that reserves be equivalent to 25 percent of current annual income; and, if they are not, that they be accumulated at the rate of 5 percent of the previous year's annual income until they reach 25 percent. The total reserves and 1948 net income of all plans met both requirements. Only the largest-size group met both recommendations. The last three size groups did not meet the 25-percent recommendation but did meet the 5-percent recommendation. The second-size group met neither recommendation. As of December 31, 1948, the reserves of 31 plans were equivalent to 25 percent of current annual income; the reserves of 59 plans were not equal to 25 percent of income, and 34 of the 59 plans did not have net income for 1948 equal to 5 percent of their 1947 income.

Based on the total number of contracts in force and the total number of participants covered as of December 31, 1948, the operating expenses of plans was $2.11 per contract compared to $2.13 per contract at the end of 1947. Cost per participant decreased from 93 cents at the end of 1947 to 91 cents at the end of 1948.

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STATEMENT OF E. A. VAN STEENWYK, EXECUTIVE DIRECTOR, THE ASSOCIATED HOSPITAL SERVICE OF PHILADELPHIA, CHAIRMAN OF THE GOVERNMENT RELATIONS COMMITTEE OF THE BLUE CROSS COMMISSION

Senator Murray. You may state your full name and anything of your background you wish to appear in the record, Mr. van Steenwyk.

Mr. van Steenwyk. My name is E. A. van Steenwyk. I am executive director of the Associated Hospital Service of Philadelphia, and chairman of the Government relations committee of the Blue Cross commission.

I have organized and managed nonprofit Blue Cross plans for 17 years. My first experience with a Blue Cross plan was in the formation of the Minnesota plan in St. Paul. It was started in 1933 with a loan of $847 from six local hospitals. I was its sole staff. I enrolled subscribers, paid hospitals, took care of the bookkeeping, and did all the staff work.

This organization now has approximately 1,000,000 subscribers. It has paid about $30,000,000 to member hospitals for the care of subscribers.

The organization of the Philadelphia plan in which I participated began in 1938 and was originally financed by a loan from the community fund of Philadelphia totaling $30,000.

This loan was repaid within 1 year with 2 percent interest, and the plan now has, after 11 years, 1,400,000 subscribers, and has paid hospitals over $40,000,000. Its current cost of operation is 8½ percent. Thus it is paying back to subscribers for hospital care approximately 91 percent of premium income.

Both of these plans—indeed all Blue Cross and Blue Shield plans—are managed by nonpaid officers and boards of directors made up of representative citizens.

My approach to the subject, therefore, is that of the practical plan developer whose concern it has been to organize community of State plans, negotiate contracts with hospitals and doctors, sell the service to the people, and be intimately concerned with the great variety of administrative problems which the provision of hospital and medical service means.

My testimony concerns the health bills S. 1679, S. 1456, S. 1106, and S. 1581. Dr. Hawley in his testimony has already touched upon the larger question of national policy. I share his views but shall make little reference to this phase of the discussion.

Instead, it is my purpose to set forth certain practical considerations which must be faced in health insurance.

First, it is of the utmost importance that any insurance device be built around methods which will stimulate local creative effort. This is necessary not just because local management assures economy of operation, but because without such management the service provided might as well not be given.

No gain is made if people are not cured of disease. All health service ought to be the closest personal service, from one human being to another. It cannot be packaged. Its character is not fixed from year to year, even from day to day.

The need for such local management is sharply brought out when one considers the three types of medical and hospital service now provided on a nonlocal, nonpersonal basis: (*a*) the mental care regulated from the capitals of the various States, the character of which has been aptly labeled by Albert Deutch as the "shame of the States"; (*b*) care of Indians by the United States Government which has been a disgrace for generations; and (*c*) the care of veterans which until General Hawley shifted the emphasis from institutional care to care by private local doctors had become a national scandal.

This is not to say that Government employees are not touched by the needs of the sick or that they are unwilling to assist them. The testimony is uniform from all who have been engaged in this work that (*a*) the necessary slowness of prudent Government administration impedes delivery of a satisfactory level of personal service to the individual: and (*b*) the uncertainties in any political system make it extremely difficult to get and keep good doctors and other needed personnel.

The assurance is fantastic that private, general, and religious hospitals will not be taken over by the Government, and that doctors and other health personnel will not become employees of the Government under compulsory health insurance. There is no other way to make it work.

Senator TAFT. Of course it would wipe out all voluntary health plans, I assume.

Mr. VAN STEENWYK. There is no doubt about that.

My second observation is that the nature of health insurance is such that no administrative pattern and no group of administrators, however wise and experienced they may be, can be as smart as all of the combinations of producers and consumers of the service which are arrayed against them.

It follows therefore that the reasonable area for administration, both geographic and in extent of covering, should be small enough to permit understanding by the administrators of as many of such combinations as possible.

The test of this is the study of health-insurance regulations. Whole libraries of regulations have been written only to become obsolete soon after being published. The present limited knowledge of health insurance makes it impossible to establish equitable regulations covering the vast geographic, climatic, economic, industrial pattern of America unless the coverage is for limited health benefits.

A third observation is that any health-insurance plan which promises more than it can actually deliver does more harm than good to the abstract values of health insurance.

This can be seen in instances where voluntary plans have undertaken to do more than either their finances, organization, or the facilities and personnel available could provide.

I have seen public confidence shattered by such inability to follow through on promises made and have observed the long painful process required to reestablish faith in the plan.

My fourth observation has to do with payment to doctors and institutions. I make no bleeding-heart appeal for either doctors or hospitals because it has been my responsibility to deal with them not solely as their representative, since they usually have adequate representation, but more as the representative of the subscriber who pays the rates. It is my conviction that any method of payment which is not completely satisfactory to the personnel and institutions offering the service does a disservice to the purpose of health insurance, that of sharing sickness expense.

I say this deliberately, realizing that it may be misunderstood to mean that I believe that hospitals and doctors should be paid what they want.

Yet it has also been my observation that no amount of money is sufficient to pay hospitals and doctors all they may want, and this is not because they are more selfish than other people. Hospitals and doctors are in truth engaged in the Lord's work, and they see no end to the things that should be done for suffering humanity.

As a subsidiary point on this matter of payment to institutions and personnel, it should be borne in mind that the larger the enterprise, the more removed it appears to be from the everyday finances of both those who are served and those serving, the more vulnerable it is to abuse.

It has been said flippantly, but with reason, that our national morals condone violations of ordinary standards of honesty if they are made against either the Government or insurance companies.

A completely satisfactory method of payment to hospitals and doctors can only be obtained through local negotiation. If Federal, State, and local tax funds are used to purchase care for those unable to pay premiums, as is suggested under S. 1456 and S. 1581, then Government regulations must help determine rates paid on behalf of its responsibilities. But it has been our experience that both method and amount of payment to hospitals and professional personnel requires thoughtful, understanding analysis of local factors including the amount of money derived locally.

Many State-wide Blue Cross plans have faced serious difficulties because of this problem. How much more difficult would this not be for the Nation as a whole?

Full cooperation of hospitals and doctors can be obtained and the kind of service desired for subscribers assured, but only as a result of local negotiations.

I know that this is the expressed intention of S. 1679, but may I respectfully point out that local negotiation based upon funds primarily obtained from local sources is an entirely different matter from local negotiation dictated by regulations from Washington without reference to the amount collected or controlled locally.

Another observation which I have had reaffirmed time after time is that while good health service costs much and is worth it, cost of itself is not a measure of worth. I have seen institutions provide high-grade services under the most trying conditions, yet do so at a cost well below that of other institutions offering no better care and having every factor in their favor.

An even-handed, just appraisal of what should be paid for health service has not yet been discovered. Methods vary all the way from paying the institutions and personnel what they want down to forcing acceptance of schedules that are plainly inadequate.

But since good health care costs a large sum of money the insured has a right to expect that before a uniform compulsory law is enacted, all experimentation will have been completed, and that a best method will have been determined upon.

If, in the judgment of others with experience, no basis for adoption of Federal compulsory health insurance is feasible or prudent except through the ownership of the hospitals and hiring of doctors and other personnel by the Government, this should be frankly acknowledged by the spokesmen of compulsory insurance so that the vain hope that medical practice will be the same under Federal compulsory insurance will no longer be raised.

Dr. Hawley has indicated that in his judgment the health services offered under S. 1679 will cost the people of this country about $100 per year per person. The cost to the family of four would therefore be about $400 a year.

I know that it may be said that under S. 1679 this cost will be distributed not only over the rich and poor, but also that one-half of the cost will be paid by the employer.

Compulsory Federal health insurance is not needed to force employers to pay part of the expense. Already many employers are voluntarily and as a result of union negotiation paying as much as half, and some the whole cost.

The general truth is that the universal trend in health insurance is toward making every self-supporting person pay for the service he receives.

The ordinary worker may expect, under compulsory health insurance, that the full load of such costs will be borne directly or indirectly by him alone.

We believe that necessary health services which at this time can be safely promised through insurance can be provided for not more than $30 per person per year if local management is given an opportunity to play a creative rather than a subservient role in national planning.

The services which Blue Cross-Blue Shield now provide to some can reasonably be offered to all through voluntary health insurance in our country at this time. These are to provide hospital and medical insurance for the hospitalized case.

The fact is little stressed, but it is still true that one-half of the medical bill of the United States is for the hospitalized illness.

One dollar out of every two spent for medical care is for this aspect of our sickness bill. This cost is borne by the 10 percent of the people needing such care. The other half of the bill is spread over the 90 percent of the people not needing hospital care.

All of the medical economics surveys have plainly demonstrated that the real economic problem for the American people is that of the hospitalized illness. As a result, first Blue Cross—the hospital plan, because it answered the most serious part of the problem, the hospital bill itself; and later Blue Shield—the doctor plan, have emerged as logical and reasonable ways of meeting this need. Let me recall for you some of the progress the nonprofit voluntary plans have made.

Ten or twelve years ago Blue Cross was just beginning to experiment with coverage of family dependents. Commercial insurance at this time could rarely be induced to offer dependent coverage; and if it did, offered not more than half of the benefits provided to the employed worker.

A typical contract provided $4 a day for the employed subscriber and not more than $2 a day for the dependent. No medical insurance could be purchased for dependents.

Blue Cross approached this field tentatively—first it took care of 10 percent of the dependent's bill, then 25 percent, then 50 percent, and finally the present uniform practice of 100 percent of dependents' bills. Blue Shield plans, too, cover dependents.

The idea of dependents' maternity coverage, now a standard practice, was considered unrealistic by insurance companies.

The matter of continuous coverage after a subscriber left his place of employment was regarded as equally unrealistic. This still is a unique benefit of Blue Cross-Blue Shield, and would tie in well with the program suggested in S. 1456 under which State unemployment compensation funds would be used to pay premiums during periods of unemployment.

The idea of reciprocity of enrollment under the Blue Cross subscribers may transfer from any plan in the United States, Canada, Puerto Rico, or Hawaii to any other plan without waiting periods or without penalties of any kind had not even been thought about, yet today it is in operation.

The same is true for reciprocity of service benefits in which most plans are now participating. Under this program a subscriber of the New York plan while in Philadelphia may use our Philadelphia hospitals and for the period of his hospital stay be accepted as a Philadelphia subscriber and obtain all of the benefits which the Philadelphia plan has negotiated with its hospitals for its subscribers, the New York plan reimbursing the Philadelphia plan what it pays its member hospitals.

Senator TAFT. What was the suggestion that, if you got over a certain income you had to pay additional? What was that suggestion made this morning?

Mr. VAN STEENWYK. That was on Blue Shield coverage, Senator. The point was made——

Senator TAFT. That is not true of Blue Cross. Not at any point.

Mr. VAN STEENWYK. Not at any point.

Senator TAFT. What about Blue Shield? They have different plans, of course, but what is the difference as you go. Over a certain income pay more?

Mr. VAN STEENWYK. No. There are certain provisions now in existence in certain Blue Shield plans that if the subscriber earns more than an agreed-upon sum he will get allowances toward his medical bill from Blue Shield, but Blue Shield does not assure such a person that the whole service will be paid for by the Blue Shield.

Senator TAFT. They treat him differently from the fellow——

Mr. VAN STEENWYK. That is right. On the basis of income. If, for instance——

Senator TAFT. You are selling a service on its cost basis, are you not? You charge more to somebody who has a bigger income. Is that the idea?

Mr. VAN STEENWYK. We do not. Let me say this: That reference was made to the Michigan plan and later discussion in the hearing developed the point that the Michigan plan gives as a credit toward the medical bill, fixed sums in accordance with the service rendered for families making more than $2,500 a year.

Thus, for instance, to the families earning less than $2,500 a year, Blue Shield says, "We will provide an appendectomy when necessary, but if you make more than $2,500 a year, then we will pay $75 or $100 toward the appendectomy and any difference which the doctor may charge is your responsibility."

Senator TAFT. That seems to me rather an unbusinesslike procedure. I cannot understand that one. It was not there when I was there 2 years ago.

Mr. VAN STEENWYK. In Michigan?

Senator TAFT. Yes.

Mr. VAN STEENWYK. Oh, yes; it has been there always. That is characteristic of all the Blue Shield plans, although I think the trend is toward developing higher income limits for full-service benefits.

Senator TAFT. I cannot see any reason for such provision at all. If it is on a pay-as-you-go basis, why do you not sell it for what it is worth. It is some effort to get the doctors more money because the people are wealthier; is that it?

Mr. VAN STEENWYK. That is the idea.

Dr. HAWLEY. May I just say, speaking for Blue Shield, on that, these fee schedules provided are very low. I mean they are much lower than would be charged normally to people of incomes of six or seven thousand dollars, and so the doctors agree to accept that fee schedule as full payment with people under that income. But for people of a greater income than that, that fee schedule does not anywhere near meet the usual fees charged in cases like that.

Mr. VAN STEENWYK. May I say one other thing on the point, and that is this: That as more subscribers are enrolled by Blue Shield, the necessity for that kind of robinhood financing of those who cannot pay anything to the doctor becomes less and less necessary.

In communities where high enrollment in Blue Shield is the rule, the tendency is toward the elimination of such income limit entirely. For instance, I think Delaware has no income limit. Delaware simply gives everybody service benefits, because it has a high enrollment and the doctors do not have that heavy burden of care to the free.

Fifteen years ago it was recognized that the nonprofit public service character of Blue Cross should be preserved, and to this end a model enabling law was drafted. Now nearly all of the States have passed special enabling legislation providing for the kind of nonprofit operation which the Blue Cross and Blue Shield represent. The vitality, inventiveness, and strength of this nongovernment insurance program is a unique phenomenon in world history. Never before has anything like this kind of public acceptance been obtained by nongovernment health insurance.

If the hospitalized illness is the serious economic problem for the American worker and his family and if the technique of protecting him against this expense is now fairly well-established on a voluntary basis, would not far greater public good come out of the extension of such practical coverage to all Americans who desire it than from continuously and futilely baying at the moon of comprehensive coverage?

Why, when even in this area of health insurance there are many unsolved problems, must we hasten to add to them and by grasping for everything risk the loss of all that is good in American health service? Why do we not acknowledge to the American people that we can safely promise only full hospital care, including medical attention while in the hospital, and emergency treatment in out-patient departments of hospitals.

Our experience indicates that no more than this should be done at the present time except on an experimental basis which is going on everywhere. Completing the job at hand will keep us all busy—Government and non-Government people and agencies. There is a role for the Federal Government in this field as stimulator, coordinator and friend. It has been set forth in outline in S. 1456, S. 1581, and S. 1106, and Blue Cross supports the general approach of these bills wholeheartedly.

Another observation born out of experience is in direct opposition to comments which have been made before this committee by the proponents of compulsory health insurance. We have learned that costs in health insurance do not get less; the trend is always to greater cost even under the best administration and under the best planning. It has been said that once the unattended ills are taken care of, a norm of demand will be established, and that from this point forward demand will slacken.

This has not been our experience. The development of sulfa drugs, sera, penicillin, streptomycin, the phenomenally rapid handling of difficult fractures—all result in gains to the insurance fund through shortened hospital stays and more rapid recovery; but financial gains are quickly offset by increases in cost of such treatments. In addition, the care of otherwise untreated and hopeless cases further increases the cost of hospital and medical service.

Twelve years ago we rarely cared for venereal diseases under our Blue Cross contract, although we never had an exclusion against such conditions. Today with new methods of treating venereal diseases in general hospitals such care is frequent, Blue Cross paying the bill.

The same is true for osteomyelitis, and many other conditions for which treatment methods have been developed. The gains are great. Many lives are being saved for useful creative work where before only hopelessly waiting for death was possible. But to infer that the first costs of health insurance are the greatest is to seriously mislead or misunderstand entirely the nature of health service demand under health insurance.

Observations like these having to do with the practical problem of establishing and administering any health-insurance program whether on a voluntary or compulsory basis need your careful consideration. They should not be brushed aside as being unimportant. There was a time in the history of the debates on compulsory health insurance when such matters received their proper attention. It has become popular within the last 2 or 3 years to give the "brush-off" to all such practical considerations as though by pretending they did not exist we might avoid the chaos which will result because of their nonconsideration.

Spokesmen for compulsory health insurance assure American people that they can perform miracles by mere passage of a law. Yet matters in which Government could really help through passage of law are resisted by them because in their opinion anything less than acceptance of their blueprint for compulsory health insurance would be inadequate.

In 1943 at the Buffalo conference of the American Hospital Association a four-point program was enthusiastically adopted by the delegates, the second point of which was later enacted into law as the Hospital Construction Act of 1947. This has proved to be one of the most effective blendings of Government and non-Government health forces, and testimony before Congress at this session urging the extension of this program has been outstanding for its evidence of constructive work in all of the participating States.

The precedent has been established for organization of the States into districts, both for analysis and provision of service. An incredible amount of time and effort has been spent by Government and non-Government people in making this program successful. These same people on the basis of what they have thus far created could with relative ease move into the area outlined in S. 1456.

Under this bill Federal, State, and local government would assist the 20 percent of the population needing such help. We are confident that with employer participation in the cost, which is rapidly developing everywhere, we can enroll the remaining 80 percent of the population in non-Government hospital and medical insurance. Also, our subscription rates indicate that we can provide all of the services which are necessary and provide all of the services which are necessary and which can be provided to those protected for not much more than one-quarter of what the Government will eventually require of each, yet at the same time provide our subscribers with the important coverage which is needed.

While the Hospital Construction Act is evidence of important assistance to non-Government health forces, the same Buffalo conference of the American Hospital Association resulted in a point four, that permission be granted for pay-roll deduction for Federal employees participating in voluntary hospital service plans by the Federal Government.

For 15 years we have been coming to Washington asking that since most large employers grant pay-roll deduction for employees desiring Blue Cross, Uncle Sam, the largest employer, do the same for his employees. For 15 years we have been giving the run-around every time we came to Washington. Why? Was it because Federal employees did not want our coverage? Not so. More than 1,000,000 are now members under an archaic collection system which costs Government far more than a simple pay-roll deduction would. Every time we have asked we have been obstructed. We are glad to see that provision has been made for this in S. 1456 and S. 1581.

In 1933 when there were no more than half million Blue Cross subscribers in the entire United States, the plans paid hospitals less than $2,000,000 for subscribers' care. Last year Blue Cross plans in the United States paid hospitals $270,000,000 for care of their 33,000,000 subscribers. Something of the development in this time may be seen from the fact that we then spoke in terms of the entire cost of non-Government hospitals as being about $40,000,000 a year.

I attended a meeting in Washington when we had enrolled 1,000,000 subscribers. We were told by those with whom we conferred—government and nongovernment people—that the mililon then enrolled was about the maximum we could expect. It was explained that this had been the usual experience in other countries—that no more would enroll on a voluntary basis, that we had done well—that although we were serious and earnest people who deserved a pat on the back, we had shot our bolt. It was absurd to think in terms of growing any larger. Yet within 2 years enrollment has risen to 4,431,000. The same people then expressed surprise over the growth, and said that it was unusual. They added, however, that the absolute maximum for American voluntary plans had at last been attained.

In 1941, 1 year later, Blue Cross had an enrollment of 6,049,000 subscribers. This time we were assured that the only reason American voluntary insurance experience had varied from the experience of other nations was because our Nation was preparing for war, and that if shooting started, the membership would diminish rapidly. Two years later in 1943, after the war had started, we had 10,500,000 subscribers.

Again the explainers stepped forward. Now and again in 1945 when enrollment had reached 16,511,000 they said that enrollment had increased only because we were at war and that when war was over membership would at once melt away. At the end of 1946, when war was over, we had enrolled 19,989,000. By this time some were willing to admit that Blue Cross enrollment was a most unusual phenomenon. Nonetheless, the record was still regarded as a flash in the pan and that membership would at some time fall off.

And so it goes. In 1947 we reported 25,876,000 subscribers, and as of December 31, 1948, 33,000,000, and this does not count 22,000,000 other Americans protected against hospital expense by labor union and commercial insurance plans—55,000,000 in all. When does such an American record become significant?

Senator TAFT. When you count 33,000,000, do you exclude dependents?

Mr. VAN STEENWYK. No.

Senator TAFT. That counts dependents?

Mr. VAN STEENWYK. That counts dependents.

Senator TAFT. That is the total number of people covered?

Mr. VAN STEENWYK. That is right.

While Mr. Ewing's book, The Nation's Health, again discounts Blue Cross in all the old dusty ways and concludes the millions of persons must permanently be denied protection of voluntary insurance, he acknowledges that this is largely so because voluntary plans cannot offer their service on a sliding scale basis, in accordance with income.

Yet the problem is one of supplementing payments made by low-income families or paying for those unable to pay. Just why an elaborate mechanism such as compulsory Federal insurance has to be established to achieve this end is not made clear, or why the sliding scale principle of premium payment is the only method of balancing demand with income.

S. 1456 would solve the problem for the needy on a basis which would contribute to their dignity and self-respect, and yet maintain the important characteristics of a sound program which I have tried to set forth. Mr. Ewing's discounting of voluntary effort is in sharp contrast to another survey made by the Federal Security Agency, United States Public Health Service in 1947 which on this point concluded:

> The growth history of the plans which have achieved substantial enrollment suggests that the first 5 or 10 percent of the population is the hardest to enroll; thereafter enrollment is easier, or at any rate proceeds more rapidly. It has sometimes been suggested that the plans as they achieve substantial enrollment in their area would reach a saturation point—a point at which they would have enrolled all those in their territory who could be reached or who could afford the subscription costs. Thus far the growth trends of the plans show no evidence of any such point having been reached.

At the end of the quote I should like to add the volume in which this appeared was the result of a very careful survey lasting over a considerable period of time in which the Blue Cross and the Blue Shield plans fully participated.

Even farm families which have been difficult to reach in any insurance program are now responding rapidly to enrollment efforts.

In summary, may I stress that the voluntary program is steadily and securely providing more care to millions more people each year, and at a cost far less than would be required under Federal compulsory insurance and that our progress may not only be relied upon to continue but would be vastly accelerated if Government would do the things suggested in S. 1456.

Trained personnel and organizations must be ready to provide the service offered under health insurance. This cannot be done from the top down. It must be built from the ground up. The greatest demonstration of successful non-Government health insurance in world history has been made right before our eyes. With Government support instead of harassment the results of the next 10 years will make the achievements of the last pale by comparison. May I assure the committee of the wholehearted support of the Blue Cross-Blue Shield plans in achieving the goal all of us desire, more and better health care to more people at the lowest possible cost.

Senator MURRAY. Is it not true that one of the main considerations in working out an appropriate program is the need for protecting the income of the doctors?

Mr. VAN STEENWYK. I am sorry——

Senator MURRAY. That one of the main considerations that is involved in this problem of health care and program is the need to protect a decent income for the doctors?

Mr. VAN STEENWYK. Yes; I would say so.

Senator MURRAY. You said a little while ago in your statement that the reason why you put some limitations on some of these plans was to reserve a large segment of the population where the doctors would be free to exact the fees that they wanted to collect in order to satisfy themselves the income they desire.

Mr. VAN STEENWYK. Senator, I was explaining the reason for an existing income limitation in the provision of service in certain existing plans. It is my own feeling that as the plans grow and develop, and as larger percentages of the populations are enrolled, the necessity for such income limitation will entirely be over. That necessity will no longer exist.

Senator MURRAY. So that the doctors generally would be able to earn the same income they are earning today?

Mr. VAN STEENWYK. Yes. I think they would as a matter of fact do better under——

Senator MURRAY. I think the average doctor would be benefited by such a program.

Mr. VAN STEENWYK. Yes.

Senator MURRAY. The average income of the doctor would be greatly increased, and that is true under the program that we are advocating also. The doctors in the lower income brackets would be greatly—their income situation would be greatly improved.

Mr. VAN STEENWYK. Well, perhaps.

Senator MURRAY. Under the program that you advocate here, do you think if it was in full operation, if you built it up to the very highest degree that would be possible, do you think that the medical men at the top of the profession would still be able to earn the incomes that they are earning now under the system that is in operation?

Mr. VAN STEENWYK. I would say so. I see no reason why they should not.

Senator TAFT. You would say that under national health insurance as to those who are at the top of the profession. They would not be in the national health insurance plan at all probably.

Senator MURRAY. That is true, if there were enough of the population left over for them to operate on and that was one of the things that alarmed the Blue Cross and made it necessary for them to fix limitations.

Mr. VAN STEENWYK. If I understand your question, Senator, you said that under health insurance, under a program such as we advocate, where doctors could earn as much as they are now earning. I say yes, I see no reason why they should not because the same open-market relationship under which they now provide their services would exist under our type of system.

Senator TAFT. They have got a selling agency out selling their services.

Mr. VAN STEENWYK. Yes; and they do not have as many responsibilities to care for the free, to care for the poor without fees, so that it should be better for them.

Senator MURRAY. Under your system, would you fix the fees that they would be able to charge, under your system?

Mr. VAN STEENWYK. We do not fix fees of physicians. We fix the fees that we pay physicians, and the physicians then contract to deliver the service which is described for that fee.

Senator MURRAY. Then if they get anything over and above that, they are at liberty to do so.

Mr. VAN STEENWYK. Only, however, under certain prescribed situations in which the subscriber has equal knowledge of those conditions.

Senator MURRAY. That is all. Any questions?

Senator TAFT. I wanted to ask one question. It has probably been answered already. These Blue Shield plans are separate plans in each State more or less or each locality?

Mr. VAN STEENWYK. Oh, yes.

Senator TAFT. And what is it? Is it just a term or is there a coordinated service that gives them information as to how these things are run?

Mr. VAN STEENWYK. I work for the Philadelphia Blue Cross plan, but I also, my Blue Cross plan in Philadelphia which is a separate entity, also acts as the agent for the Blue Shield plan in Pennsylvania. Dr. Hawley works for a national agency which coordinates our work, but each of the plans is separate.

Senator TAFT. Also in Blue Cross that is true. That is, each plan is a State plan or a local plan.

Mr. VAN STEENWYK. That is right.

Cincinnati has a Blue Cross plan; Missouri has a Blue Cross plan; Montana has one. But each is separate.

Senator TAFT. Each of those operates, presumably, on a sound financial basis of its own, and receives no assistance from any national organization.

Mr. VAN STEENWYK. That is right.

Senator TAFT. Simply advice and guidance, is that it, from the national organization?

Mr. VAN STEENWYK. That is right.

Senator DONNELL. No questions.

Senator MURRAY. We will meet tomorrow morning at 10 o'clock.

(Thereupon, at 5:45 p. m., the committee adjourned, to reconvene Wednesday, June 1, 1949, at 10 a. m.)

NATIONAL HEALTH PROGRAM OF 1949

WEDNESDAY, JUNE 1, 1949

United States Senate,
Subcommittee on Health of the Committee
on Labor and Public Welfare,
Washington, D. C.

The subcommittee met, pursuant to adjournment, at 10:05 a. m., in the committee hearing room, Senator James E. Murray (chairman) presiding.

Present: Senators Murray and Taft.

Senator Murray. The hearing will come to order, please.

The first witness this morning will be Mr. James B. Carey, secretary-treasurer of the Congress of Industrial Organizations, and associated with him will be Anna Hilton, of Camden, N. J. Good morning.

STATEMENT OF JAMES B. CAREY, SECRETARY-TREASURER, CONGRESS OF INDUSTRIAL ORGANIZATIONS, ACCOMPANIED BY ANNA HILTON

Mr. Carey. Good morning, Mr. Chairman. My name is James B. Carey, and I am appearing on behalf of the Congress of Industrial Organizations, of which I am secretary-treasurer. I also serve as chairman of the CIO Committee on Health, Safety, and Welfare.

The CIO supports S. 1679, the National Health Insurance and Public Health Act. The program contained therein would greatly expand medical facilities and services, and would launch a national program of comprehensive health insurance covering wage earners and other important groups in the population. The CIO has for years supported such a national program. Our members want it passed at the earliest possible moment. Illness and doctor bills do not wait for legislative action. Each day our members suffer from lack of proper medical care and from the overwhelming costs of the service they do obtain.

Medical care at its best in this country is excellent. We want to be able to use first-rate hospitals, physicians, specialists, laboratory tests, and the other marvelous advances of medical science. Our aim is to supplant second-rate and second-hand medical care which is the lot of millions of Americans, if they get any at all.

The rising American standard of living includes good health, and our members are demanding that the Federal Government take action to assist them to get it.

We seek to obtain our objectives through collective bargaining as well as through legislation, but we know that collective bargaining is not a substitute. It can take care of our needs pending national action, and it can supplement whatever insurance program is enacted. Unions are often accused wrongly of being selfish and seeking their own welfare without regard to the needs of the unorganized. We advocate a national compulsory program in part because we want everyone covered and sharing in the benefits.

The program for improving the Nation's health embodied in S. 1679 is constructive and well-rounded.

There is great need for the first title, giving Federal aid for the education and training of physicians, dentists, nurses, sanitary engineers, hospital administrators and other health personnel. The aid would be extended in such a way as to encourage expansion of professional schools, by giving generous grants for each new student added above recent average enrollments.

This title would stimulate a rapid increase in the number of doctors and other medical personnel, thus helping to overcome existing shortages.

The aid to medical research incorporated in title II of the bill provides for the establishment of additional institutes for special study of serious diseases such as diabetes, poliomyelitis, and arthritis.

Expansion of hospital facilities and of public health services, as provided in titles III and V, are also essential to meet shortages and to improve the functioning of local public health units. Although a separate subcommittee is considering these sections, too, we wish to express to you our great interest in their passage. We have a similar concern with the liberalization of maternal and child-health services, as incorporated in title VI, also under consideration by the Hill subcommittee.

The special aid for rural and other shortage areas short of personnel and facilities would greatly benefit the large number of our members who live in such areas. Such special aid, is needed in the next few years if they are to have good doctors, hospitals, clinics, and other essentials for modern medical care. We endorse the idea of assisting farmers' experimental cooperatives and hope the interpretation will be such as not to exclude industrial workers in rural areas who wish technical assistance and funds for the formation of cooperatives.

It is appropriate to include these first six titles for the expansion of facilities and services in the same bill with the last section, which would establish national health insurance on a prepaid basis with free choice of doctors. If people are to be able to make full use of expanded facilities methods of financing medical care must be improved through such an insurance program.

The bill as a whole would aid the entire community—except some patent drug manufacturers and others who now profit from illness, poverty, and ignorance. Even the minority who can now afford first-rate medical service would benefit from the higher standard of public health, the new research discoveries, the conquering of contagious diseases, and the greater measure of community well-being.

The great majority of the people, who are self-supporting but cannot meet the costs of heavy medical expenses, would be insured against those costs, and doctors would be within reach. With removal of financial barriers to good medical care, Americans would be able to seek the help of their own doctors at the first warning signs. They could then receive necessary tests and treatment, thus averting needless complications. Worries over the terrific costs would not torment them during periods of illness nor haunt them in times of good health.

The lowest income groups, who for some reason are not self-supporting, would also be protected. Their insurance fees in the national health system would be met. People who already had had to turn to their Government for public assistance on a needs basis would be assured of good medical care, but the means test would not be imposed just for medical care as under other bills before your committee.

I should like to emphasize at this point that any adequate health legislation must meet the needs of the middle-income group of Americans, not merely the low-income groups. Both the Taft bill, S. 1581, and the Hill bill, S. 1456, completely fail to meet the needs of the self-supporting majority in the middle-income group. Any measure that emphasizes help on a charity basis is a step backward. People should not be required to prove that their incomes are low or that they have no resources. It is bad enough to be poor without having to prove it, and without having investigators snoop around to see that you have not lied.

Some groups, because of adversity and inadequate insurance programs, must be helped on the basis of need, but these groups should be kept to the minimum by providing a universal adequate social insurance program, covering all major economic hazards, namely old age, survivorship, temporary and permanent disability, whether from sickness or accidents, unemployment, and the costs of medical care. Measures to make a long advance toward such an adequate insurance program have been introduced in this Congress. We hope they will be passed, including S. 1679. It would be tragic, and unforgivable, if this Congress should place emphasis on helping people when they are completely down and out, instead of enacting insurance programs that will enable them to receive adequate benefits as a matter of right and thus to avoid having to seek that last resort, public assistance.

The program of national health insurance contained in S. 1679 includes many valuable basic principles.

There is no interference with the free choice of doctors or patients, and doctors can continue practicing as individuals if they choose, although group medicine is likewise permitted. Voluntary cooperative groups are encouraged insofar as they provide service. The employees of the CIO, for example, who now belong to Group Health here in the District, could continue to get medical care through that cooperative. An increase in consumer cooperatives would undoubtedly occur due to the other titles in the bill.

The insurance program would be on a uniform Nation-wide basis. The large number of workers who move from State to State would not be confused by State variations nor risk losing coverage. We would avoid the deficiency and complexities that plague us under the present State unemployment compensation systems. The existing records now kept for old-age and survivors' insurance would readily show which persons were entitled to medical care insurance so that they could receive their cards at the beginning of each year.

The control of the program would be kept where it belongs, in the hands of the people's representatives appointed in the executive branch of the Government and on advisory boards, National, State, and local, Consumers would be in the majority, not the doctors or hospital administrators whose actions in opposition to medical cooperatives and health insurance have shown their lack of sensitivity to the people's needs. Both the Taft bill and the Hill bill, in contrast, would in effect leave control in the hands of medical societies or hospital administrators, or subsidize private organizations without any Federal controls or standards.

It is sheer folly to argue that Congress can fulfill its obligations to promote public health by granting funds to the States and letting the States draw up their own incomplete or conflicting provisions, under medical societies or Blue Cross control, with accompanying grave danger that consumers cooperatives, such as Group Health, would be knifed.

It is by no means true that a State program is closer to the people than a national program. At conference after conference of our State council representatives there has been unanimous agreement that we want a national system of social insurance, not a bewildering and inadequate maze of State systems.

Our States governments have unfortunately in many cases remained or become highly undemocratic, as shown very effectively by the United States Conference of Mayors. I wish to file with the committee a recent publication of the Mayors' Conference entitled "Government of the people, by the people, for the people." I have had parts of that publication mimeographed and append it to my statement. I have time here to quote only a few sentences:

> But in our State legislatures today we do not have equality of representation. Fifty-nine percent of the people of this country elect only 25 percent of the State legislators.
>
> Who are the second-class citizens in this underrepresented majority? They are the 84,000,000 people who live in our towns and cities; 59 percent equals 25 percent is bad arithmetic—and bad government. It hurts not just city dwellers, but everybody.

Senator MURRAY. Is that a lengthy document?

Mr. CAREY. It is a document containing a lot of charts and pictures that may be of interest to the committee. I would like to file it.

Senator MURRAY. It will be received as an exhibit.

(The document above-referred to is filed with the committee.)

Mr. CAREY. I recommend this publication to all those who are misleadingly told that Congress can best promote health by giving funds to the States with inadequate standards.

The proposed national health insurance program provides for pooling of risk, with contributions roughly in proportion to ability to pay. Thus better-paid workers would contribute more each year than low-income groups, although all would be entitled to the same services. This approach follows that already incorporated in our old-age and survivors' insurance program, although their benefits as well as contributions are roughly in proportion to income.

The bill before you implies, although it does not specifically provide, that taxes on employers and employees would be 1½ percent of pay rolls for each group. The CIO would prefer to have taxes apportioned on a still fairer basis, holding down the pay-roll taxes and providing a substantial contribution from general revenues of the Government, which in turn should be derived from a progressive income tax and other progressive taxes. But we recognize that the system of financing in the administration bill is more equitable than that in the present voluntary organizations, such as Blue Cross, Blue Shield, or even Group Health, where all participants are charged alike regardless of income.

Most State insurance laws provide that such voluntary groups must charge the same rate for the same service. This may be sound as a requirement for private profit-making organizations but illustrates their limitations as compared with social insurance established by the Government.

Another advantage of the latter program is that it would provide much more extensive protection. It would cover virtually all Americans. It would pay the cost of virtually all types of medical services unless for a time shortages made this impossible. It would cover a far larger part of the cost of medical services than is now provided by the voluntary plans. This would be true especially for the self-supporting middle-income majority for whom the Blue Shield plans, run by the medical societies, pay only certain minimum amounts of medical fees.

The voluntary groups are limited by their very nature from providing comprehensive care to everyone. Since belonging to them is a matter of choice they naturally try to protect themselves from an undue load of persons who already have ailments or who, because they are old, are likely to require extensive care. For example, the plans of the Blue Cross and Blue Shield in the District of Columbia, known as Group Hospitalization, Inc., and Medical Service of the District of Columbia, exclude from both the hospital service plan and the surgical service plan "benefits for any illness or abnormality known to exist at time of application for participation in the plan." Membership must be based on regular employment by an organization in which a group exists, and no one 65 years of age or older may be covered even though a member of the family.

I should like to file with your committee two leaflets of these District of Columbia organizations.

Senator MURRAY. They will be received.

(The documents above referred to are filed with the committee.)

Mr. CAREY. Since I understand that it is difficult to obtain comprehensive and exact information on the services, fees, and limiting conditions of the various Blue Cross and Blue Shield plans, I respectfully suggest that your committee seek to obtain such comprehensive information for inclusion in your record or report. Such information, we believe, will confirm our contention that voluntary plans cannot meet the need for insurance against the costs of medical care.

Mr. Chairman, the case for national health insurance can be illustrated by many individual stories of needless suffering and tragedy. One such case is to be presented to you today as part of our CIO testimony. It speaks more strongly than any further words of mine could do.

Senator MURRAY. The printed excerpts from Government of the People, by the People, for the People published by the United States Conference of Mayors will be incorporated in the record at this point.

(The document above referred to is as follows:)

EXCERPTS FROM GOVERNMENT OF THE PEOPLE, BY THE PEOPLE, FOR THE PEOPLE, PUBLISHED BY THE UNITED STATES CONFERENCE OF MAYORS

Government of the people, by the people, for the people?

Why the question mark?

Certainly we believe it.

Don't we actually have it?

In our State legislatures the answer is "No."

Representation is the basis of our structure of government. Unequal representation is not democracy.

Equal representation is not a mere theory or doctrine. It is a fundamental feature of democracy; and the failure of any legislative body to enforce the principle should be met with instant and vigorous protest on the part of the people affected. The importance of this principle was well expressed by the Supreme Court of Kentucky (*Ragland* v. *Anderson*, 125 Ky. 141) some years ago when it said:

"He has studied our Constitution in vain who has not discovered that the keystone of that great instrument is equality, equality of men, equality of representation, equality of burden, equality of benefits. * * *

"Equality of representation is a vital principle of democracy. Without equality republican institutions are impossible. Inequality of representation is a tyranny to which no people worthy of freedom will tamely submit. To say that a man in Spencer County shall have seven times as much influence as a man in Butler or Edmonson county is to say that six men out of every seven in those counties are not represented in the Government at all. They are required to submit to taxation without representation.

"Equality is the basis of patriotism. No citizen will or ought to love the State which oppresses him; and that citizen is arbitrarily oppressed who is denied equality of representation with every other of the Commonwealth."

But in our State legislatures today we do not have equality of representation.

Fifty-nine percent of the people of this country elect only 25 percent of the State legislators.

Who are the second-class citizens in this under-represented majority? They are the 84,000,000 people who live in our towns and cities; 59 percent to 25 percent is bad arithmetic—and bad government. It hurts not just the city dwellers, by everybody.

Our urban millions are underrepresented today because—

1. Area representation (with no regard for population): Each town or county, no matter how populous, is represented sometimes equally in the upper house of most States.
2. Failure to reapportion (in accordance with population changes): Both growing and declining districts elect the same number of State representatives as they did years ago in both houses of most States.

Situations like this exist in all parts of the country:

Michigan, lower house: Wayne County (Detroit)—40 percent of population, 27 percent of representation.

Georgia, lower house: Fulton County (Atlanta)—population 393,000, three representatives; Echols County, population 3,000, one representative.

Delaware, both houses: New Castle County (Wilmington)—67 percent of population, 42 percent of representation.

Oklahoma, lower house: Oklahoma City—population 244,000, seven representatives; seven rural counties, population 57,000, seven representatives.

California, upper house: Los Angeles County—39 percent of population, 2½ percent of State senators.

Missouri, lower house: St. Louis—population, 816,000, 18 representatives; 18 rural counties, population 158,000, 18 representatives.

Oregon, both houses: 55,406 urban people per senator, 9,072 rural people per senator, 22,202 urban people per representative, 5,272 rural people per representative.

Connecticut, lower house: Hartford—population 166,000, 2 representatives; Colebrook—population 547, 2 representatives.

Pennsylvania, lower house: Allegheny County (Pittsburgh)—population 1,400,000, 27 representatives; 36 rural counties—population 1,200,000, 36 representatives.

Illinois, both houses: Cook County (Chicago)—51 percent of population, 37 percent of representation.

Colorado, lower house: Denver County—21,500 people per representative; Baca County—6,207 people per representative.

Ohio, lower House: Cleveland—16 percent of population, 7 percent of representation.

Maryland, both houses: Baltimore—47 percent of population, 29 percent of representation.

Wisconsin, lower house: 67,447 urban people per assembly district, 15,827 rural people per assembly district.

Iowa, upper house: Polk County (Des Moines)—population 195,835, 1 senator; Mahaska County—population 26,485, 1 senator.

Rhode Island, lower house: Providence—36 percent of population, 25 percent of representation.

Montana, upper house: Silver Bow County, (Butte)—population 53,207, 1 senator; Petroleum County—population 1,083, 1 senator.

Urban underrepresentation has its origins in our early history as a rural nation * * *

By 1790 constitutions for the Thirteen Original States had been adopted. In that year there were less than 4,000,000 people in the whole United States, 95 percent of them lived on farms or in tiny villages, widely scattered, each small group quite isolated and having its own particular interests in its own township or county. It is not surprising that each town or county wanted to have some representation in the State legislature. Provision for this area representation was the only departure from equal representation of the electorate in early State constitutions. Some State constitutions still provide for it.

Only 5 percent of the people lived in cities and towns of over 2,500 people in 1790. This small minority was generally distrusted by the farmers who made up the bulk of the population. Rightly or wrongly, cities were regarded as "ulcers on the body politic" and their people as "immigrants and criminals and general rabble." Cities did have representatives, however, and in one house they usually had the full number to which their population entitled them. But throughout our early history, towns and cities were so few and so small that altogether their voices in the State legislatures were few.

All State constitutions provided, however, for periodic reapportionment, usually every 10 years, to take account of population changes. Equality of representation became the constitutional rule in most States and in the others only the provision that each town or county have at least one representative was a departure from this basic principle of democratic representative government. These constitutional principles, however, have not been lived up to in practice.

It continued as we became an urban nation * * *

As the Nation grew, the bulk of its increase was in urban population.

But these new urban millions did not get their fair share of representation. State legislators, predominantly from rural districts, blocked the periodic reapportionment provided for in the State constitutions and so maintained their own jobs and their own control.

In most States today reapportionment is overdue. Mississippi has not reapportioned since 1892, Kentucky since 1893, Illinois since 1901, and it is 10, 20, even 30 years overdue in many others.

What started as a little underrepresentation, a minor slight to a small urban minority has become today a gross injustice to 84,000,000 people.

Mr. Carey. I would like to present Anna Hilton.

Senator Murray. Do you wish her to testify before you are cross-examined?

Mr. Carey. Perhaps you would care to question me now on the testimony I have presented.

Senator Murray. We will hear Mrs. Hilton now.

Mrs. Hilton. Mr. Chairman and members of the committee, my name is Anna Hilton. I live at 819 Tulip Street, Camden, N. J., with my husband and two children.

I am here today to tell you what a serious illness has done to my family—to its savings, to its living standards, to its self-respect, and to its plans for the future.

My husband, August, is 41 years old. All his life he has worked hard and his wages were more than adequate to support our family. For the last 10 years—prior to his illness—he worked in Camden shipyards as a welder. He was a member of the CIO Shipbuilders Union and earned a base wage of $60 a week. With overtime and incentive pay, his earnings averaged about $75 a wek.

Up to July 1948, we had accumulated about $1,000 in savings, with which we had intended to make a down payment on a house.

Then illness struck. In July of last year, my husband was rushed to the hospital for an appendectomy. Before the operation, my husband's appendix was ruptured. He was stricken with generalized peritonitis. He remained in the hospital for about a month. Then he returned home in a slightly improved condition. But the peritonitis became chronic and in a few days he was returned to the hospital. His condition became steadily worse, until he was finally placed in a brace from his neck to his legs.

After 8 months' hospitalization, he was finally taken home 2 months ago—on April 5, 1949. He has been in bed at home ever since. The doctor says his condition is grave and the chances of recovery are slim.

That's the story of what happened. Now I'd like to tell you about its costs.

My husband had considered the possibility of an illness in the family and we carried Blue Cross hospital insurance. This had cost us $2.50 per month, or $30 a year, for family coverage. But the policy only covered his hospitalization for 1 month. It did not provide anything for medical expenses or medicines.

The hospital bill alone totaled $4,508.90. Doctor bills and prescriptions cost us an additional $770. The total cost to date, therefore, of my husband's illness has been $5,278.90.

Of this amount, Blue Cross paid only the first month's hospitalization—$648.45. This totally inadequate amount was less than one-eighth of the total hospital and medical expenses. In addition to the $645.45 from Blue Cross, we have exhausted our $1,000 savings and used practically every cent of our family income to pay $2,168 in hospital bills and $770 in doctor and prescription bills.

During 1948, my husband's 6 months illness cost 54 percent of the family income. Despite our tremendous outlays, we find ourselves today with a $1,692.45 debt still owed to the hospital for my husband's hospitalization. Through the efforts of the Union Organization for Social Service—an agency representing CIO, AFL, and independent unions in the Camden area—arrangements have been made for us to repay our debt to the hospital at the rate of $5 per week. At this rate, the balance will not be repaid in full for 6½ years.

To help meet the medical bills, I had been working at the Howland-Croft Mills textile plants as a weaver until January of this year. As a member of local 229, Textile Workers Union of America, I earned a base pay of $31.76 per week. But now it's impossible for me to work, because taking care of my husband at home is more than a full-time job.

So our only family income at present is the $40 a week my son, August, Jr., who is 20, earns as a welder in the RTC Shipyards. My daughter, Shirley, who is 17, is graduating from high school this month and is already looking for work.

I might mention that while in the hospital my husband had a semi-private room. A private room would have helped his recovery, but this was out of the question financially. At home, now, he is in a hospital bed, which was obtained for us by the Union Organization for Social Service.

You may be interested in the humiliating red tape we had to go through to get this bed from the welfare department. We had to fill out the same forms and supply the same information as a pauper applying for poor relief. I have a copy of the form here, and, as you can see, it requires such information as rent receipts, gas and electric bills, birth certificates, marriage license, personal character recommendations, and so on.

Because of my personal and family experiences, I certainly hope this committee will give serious consideration to the passage of the national health insurance bill, as recommended by President Truman. From my own experience, I know voluntary Blue Cross plans are utterly inadequate to do the job. And I am certainly opposed to any pauper's tests for receipt of medical care. We should get it as a right, through pay-roll taxes for health insurance, just like old-age social security. I heartily indorse S. 1679 and urge its prompt pasesage.

Senator TAFT. What is the name of the hospital?

Mrs. HILTON. Cooper.

Mr. CAREY. Cooper Hospital in Camden, N. J.

Senator MURRAY. Do you wish to ask any questions?

Senator TAFT. No.

Senator MURRAY. Mr. Carey, I understand that your conclusion and the conclusion of your organization, after careful study, is nothing less than a Nation-wide plan of health care. health insurance, will take care of the situation in this country.

Mr. CAREY. That is correct, sir.

Senator MURRAY. Such a program, too, do you think, would lessen the numbers that finally get into the indigent class in this country?

Mr. CAREY. Oh, it would considerably. In fact, that is one of the important reasons that we support the compulsory insurance program.

Senator MURRAY. I remember reading some time ago that in an investigation of the hundred neediest cases that are published in New York City every year, an examination of those cases revealed the fact that many of them get into that situation as a result of illness and the excessive costs that finally bankrupt them and put them in that situation.

Mr. CAREY. Yes, sir; and it is a great waste in terms of human resources. I might say that our files are full of examples of people that have spent a large part of their lives working at reasonably good salaries and regular incomes, and then find that due to conditions that they could not anticipate, as in the case of the Hilton family, they are in very difficult circumstances and it was necessary, Mr. Chairman, for organizations, labor organizations and cooperative groups to take into account some of the adversities of their members and to take what steps they could to meet some of their problems, but it will require action by the Federal Government. We believe the best action they could take would be the immediate enactment of the bill before this committee.

Senator MURRAY. And that situation applies to people in business, too, small independent businessmen, men who are working for themselves.

Mr. CAREY. Yes, sir; it does as well.

Senator MURRAY. A great many of them are often affected in that same manner in which the Hilton family is affected.

Mr. CAREY. It is extremely difficult to measure the fear growing out of the insecurity from that very situation. It is a haunting fear confronting American families, and we consider it an unnecessary burden that the people are carrying.

Senator MURRAY. I understand that Dr. Hawley, who was a witness here yesterday, at one time suggested a Nation-wide program to the American Medical Association, but they refused to consider it—practically threw him out, as the papers reported it at the time, would not have any such thing as a Nation-wide program. They believe in State programs and programs set up by the American Medical Association or State associations.

Would you care to discuss the——

Mr. CAREY. Pardon me, sir. They believe in State associations that the American Medical Association controls without the recipients of the services of the profession having anything to say about the standards being exercised.

Senator MURRAY. You do not think those kinds of plans would fit the situation?

Mr. CAREY. They have not fit the situation today, sir. The States of this country have had adequate opportunity to meet the needs of the people. The American Medical Association has failed in its proper responsibilities to meet the needs of the people as represented by the many examples that we could place before this committee, and I am not surprised that they did not accept favorably Dr. Hawley's proposals.

Senator TAFT. Did Dr. Hawley in his testimony yesterday make that statement?

Senator MURRAY. No.

Senator TAFT. Did you ask him whether he had made it when on the stand?

Mr. CAREY. It is public information that he did.

Senator MURRAY. He told us here that he was in constant conflict with the American Medical Association and that he disagreed with them in almost every respect.

Senator TAFT. He said that, but I did not hear him testify that he ever presented a compulsory medical plan. I did not hear you ask him whether he did.

Senator MURRAY. No; he did not, but I think that is assumed and that is accepted.

Mr. CAREY. It is not only assumed, Senator. It was contained in the doctor's public statement carried in newspapers this morning that he had made proposals that had been rejected by the medical society.

Senator MURRAY. He was not proposing, of course, a compulsory plan, but a Nation-wide program, instead of a series of individual plans in the different States.

Now my understanding is that the main factor which induces the American Medical Association and the medical profession to oppose a national-health system is the fear that it would interfere with their right to earn good incomes. Now I believe the medical profession is entitled to incomes commensurate with the training and time they have to spend in college learning their profession, and they should be well paid. I do not think anybody wants to deny the medical profession the very finest kind of an income when they are qualified and give good services.

Mr. CAREY. Senator, I might say at this point, if I may, that a great part of my time is taken up trying to improve the standards of people, and the CIO itself was created for that purpose, and we fight for the standards of people that are not members of our organization because we believe that if the standards in, say, the teaching profession were raised, we would get better services for the people that our organization serves, and the same thing is true for the medical profession.

We believe that through an improved organization, the standards of the profession would be raised and therefore the services could be raised.

Senator MURRAY. That always seemed to me to be one of the main factors which induced them to make the arbitrary fight against a national-health program. I have always felt that it would raise the income of the great majority of the medical profession, and that it would be a great benefit to the country as a whole if we had a system of a kind that would enable people to go and get treatment before their condition became serious.

It is a very important factor in maintaining the health of the people, that they should go to a doctor at the commencement of their illness and not put it off. That is your idea, is it not?

Mr. CAREY. That is correct; yes, sir.

Senator MURRAY. You mentioned that, I believe, in your testimony with reference to preventive medicine and the need for going early to the doctor for examination.

Mr. CAREY. Yes, sir; that is contained in my testimony.

Senator MURRAY. Now we are told that the laboring people do not want further pay-roll deductions. You said that you thought lesser deductions should be considered because of the drain on the working classes and on the people in the low-income brackets. What is your idea with reference to that?

Mr. CAREY. Of course, Senator, these labor leaders in this country are about the only group that operate nongovernmental organizations that have to win federally conducted elections before they speak for workers, and our credentials are in order in terms of speaking for our members. We have the means of getting their views expressed through our meetings and our constant contact with them.

Senator TAFT. How long is it since Mr. Petrillo had an election as to whether he represents the musicians?

Mr. CAREY. I started out by saying I am James B. Carey. I speak for the CIO.

Senator TAFT. Or Mr. Lewis. Do you know how long it has been since he has had a real election?

Mr. CAREY. I do not know about Mr. Petrillo, but Mr. Lewis when he was associated with the CIO was elected as the president every year. He served in that capacity, whereas our Senators are elected every 6 years.

Senator TAFT. Mr. Lewis was elected by the people he had appointed district managers, if you remember.

Mr. Carey. You missed the point I made. I tried to say that Lewis was elected president of the CIO, when he was president and I was secretary, every year, whereas Senators are elected every 6 years, but I would not say that reflects on their credentials in terms of representing the workers.

I am merely pointing out that we have to provide credentials under the regulations that Congress provides, before we can be spokesmen for labor, and our credentials on this particular issue are very well in order because this question of health is a matter that is uppermost in the minds of our people. It is one of the few items that there is not some opposition to, this national-health program.

We have unanimous support on the part of laboring people for the kind of compulsory program, and I emphasize that. Despite the opposition of American workers to socialization or communism and these other slogans, they see through the kind of propaganda today directed against this, and since you mentioned Petrillo, Senator, I am just wondering when you are going to apply the Taft-Hartley law to this labor leader Fishbein of the medical union.

I also think that perhaps if some labor union, even Lewis or Petrillo, assessed their members $25 apiece to engage in a lobby campaign, there would be a little excitement down on the floor of the Senate.

Senator Taft. Well, I do not know. We had a gentleman here who testified that the AFL and CIO——

Mr. Carey. Senator, I am just jealous of Fishbein's ability, you see, to get by with a lot of these things.

Senator Taft. He was asked how they raised their political funds and he said they were raised by so-called voluntary contributions. That was in the testimony here 3 months ago on the Taft-Hartley law, so the doctors seem to be raising it also by so-called voluntary contributions.

Mr. Carey. Except that if they do not pay it, they cannot use the facilities of the profession, you see, and all of that. Now that runs into some very important questions.

I cannot understand their opposition to compulsory programs if they engage in compulsory programs themselves, but, of course, that is an aside. I would not expect the same standards.

Senator Taft. As a matter of fact, they are not compulsory, of course. They cannot make a doctor pay $25 if he will not.

Senator Murray. Would you have any objection to the AMA program of assessing their members $25 apiece if they would devote those funds to a study and promulgation of some kind of a system that would take the place of the program that we are offering?

Mr. Carey. If there is any group that needs an educational campaign, it is that particular group in terms of the ordinary needs of ordinary citizens, and that is, and I mention again, one union that needs a little attention where the services that they contribute to society are not up to their ability to do it, and I think they ought to get over the notions that every program that is suggested in order to provide improved conditions in terms of health is directed against the American Medical Association.

If the American Medical Association or these voluntary groups had rendered this service, perhaps this question would not be as heated a one as it happens to be today. I do not think they are objective in their studies, and quite frankly I would not have confidence in them to conduct an educational program on this question.

I would suggest perhaps that the Senate, this committee, might look into some of these programs, and that is what I suggested in the testimony, to get the propositions contained in these voluntary plans and look at them in terms of what happens in the case of the Hilton family, what happens in the case of the family, not just a family that has not had an adequate income, but above the average in terms of standards of income for workers, and see what happens to them under these voluntary plans when they are confronted with a situation that is not unusual.

Senator MURRAY. Any questions, Senator?

Senator TAFT. Mr. Carey, do you regard this catastrophe type of illness as the main argument for compulsory medicine?

Mr. CAREY. I am not speaking of catastrophe type of illness, Senator.

Senator TAFT. We are taking the case that is advanced as the main argument here, the case of the Hilton family. That I suppose might happen to 1 person in 40 or 50.

Mr. CAREY. Well, it has happened to my family, Senator. The question is this. It affects every family. There is not a working family in this country——

Senator TAFT. Nothing like this, however, as far as I know, is common. Ordinarily the hospitalization over a month is rather a rare thing.

I do not suppose you can count more than 1 family in 50 in the country who requires it. Now what I want to know is whether you are particularly interested in this catastrophe insurance because I see the argument for it entirely.

Mr. CAREY. That is entirely——

Senator TAFT. And it might be that such a plan, a plan covering something of that sort might be handled, but I do not quite see why we hit the other 40 people and set up a whole system of the dispensation of medicine for everyone simply to deal with this one problem where a family has a perfectly adequate income, if it is spread properly.

This family had an income of about $6,000 a year. If the right kind of insurance is available, it would cover that. We can go further than our bill. We can make it compulsorily available for such an extreme case. We can make that a condition, if we want to, but is that not a special and limited problem? That is the question that I ask.

Mr. CAREY. Senator, I do not see it that way as a limited problem because I see it as a problem, a fear that confronts all of us.

Senator TAFT. It is a fear surely, and therefore the insurance should be available to all, and they ought to be able to meet that fear through some kind of insurance. As to what kind, that is the question we are debating and discussing.

That is not what concerns me so much in this whole thing. My opposition is to setting up a tremendous Federal bureau undertaking to deal directly with every family in the United States to provide free services of certain various kinds to be determined by law and regulation. I shudder to think of setting up on top of our present organization any such vast Federal service, if you want to call it that.

Mr. CAREY. I can think of a lot of Federal services less important than this one.

Senator TAFT. We have been trying to single out the things that are specifically wrong and trying to deal with them. This is one of them unquestionably, this catastrophe illness question, but I do not think it argues that therefore we must furnish free medical service of all kinds to 150,000,000 people. That is where my doubt arises about it.

Mr. CAREY. Well, measuring it in terms of the security that is derived from it not only for the individual and the individual family, but for the Nation, you raise the health standards of the people of this country through improving the services——

Senator TAFT. I do not think you raise the health standards any. Take the Hilton case. With many it is a financial problem. To most people it is a financial problem.

Mr. CAREY. Senator, do you think we raised the educational standards of our country by compulsory education? I think we did.

Senator TAFT. Yes, because you had no private system practically, or a very limited one. Here you have an almost complete medical system already existing in the United States.

Now shall we federalize the whole medical system and that is about what it must come to in the end, or shall we try to improve that system and meet the particular complaints, the particular faults that have arisen? That is the problem we have.

Mr. CAREY. That is the problem. I think there has been a considerable time devoted to a discussion of that approach, and I am reporting here that in the opinion of the CIO and its members, the voluntary approach has not given adequate service. The voluntary approach does not meet the needs of the people, and that puts a responsibility upon Congress to deal with that question.

Senator TAFT. I agree that in many cases your private system does not work. I do not think it works in housing. Even so I think Government action ought to be confined to just as limited a field as possible unless we are going to have the Government gradually take over everything.

May I ask one thing about these legislatures? I served in one in Ohio for quite a while. While Ohio is not as bad as others from a rural-city standard, still the House is subject to criticism because of an amendment that got in the Constitution giving one representative to every county.

Why would that affect this health question, however? Are not the rural legislators, the farmers just as much concerned—we are so told—about the health problem as the city people? In fact, are they not in some respects less well cared for as far as health is concerned? What has the misrepresentation in the legislature got to do with health?

Mr. CAREY. Well, I was quoting from the Conference of Mayors.

Senator TAFT. They claim that the city people are discriminated against. I agree. There is a disproportion in the State legislatures, but for Heaven's sake, what about the disproportion in Congress? No State legislature has misrepresentation that the Senate of the United States has.

Mr. CAREY. Well, recently I have found that our Federal Congress is more responsive to the needs of the people.

Senator TAFT. How recently? Do you mean in the last month in the House?

Mr. CAREY. Well, since the creation of the Political Action Committee, I will put it that way.

Senator TAFT. I do not think there is a legislature in the country in which so many people are so underrepresented as they are in the Senate. Here is the State of New York with 13 or 14 million people and two Senators, and here is the State of Nevada with 150,000 people and two Senators. How are the State legislatures any more disproportionate than Congress?

Senator MURRAY. Well, Senator, with the very limited representation that New York has, it seems to get along pretty well.

Senator TAFT. I always found that the cities in Ohio get along very well. We got what we wanted if we went about it in the right way, and I am only suggesting that the argument against State control, because farmers are somewhat overrepresented, certainly does not apply to health, and I do not think it applies generally to opposition to giving the States autonomy.

Senator MURRAY. I am afraid that if New York was represented any better, that the wealth of the whole Nation would be centered right in New York City down around Wall Street. It seems to me that the constitutional provisions are very wise—of course, the northeastern section of the country got a pretty good start in this country before the West was developed. After the Civil War they went ahead and through the expansion of big business and monopoly they have obtained pretty good control of the country. So I do not think we need cry, weep, shed any tears about the lack of representation of the big industrial States of the East.

I think what we need is to find out how we are going to develop the balance of the country and take care of the increasing population we have on our hands. We cannot settle them in the eastern sections any longer, and we must provide some way for them to spread out.

Mr. CAREY. Well, Senator, I would go along with Senator Taft's proposal, if I understand it properly, that we could expect some friendly competition between our levels of government to render services to the people.

I would take that not as an excuse for the Federal Government not doing it because the State governments should do it and do not. Now if the State governments respond to the needs of the people in terms of health standards, I would say we could look forward to some friendly competition there, and the people in this country would have greater confidence in their State governments rendering service, but too long have we faced this State's rights argument as an excuse for not doing what should be done by Government to meet the needs of the people.

I have little fear of government because I believe that in our form of government there are the checks and balances that are necessary, and I resist this campaign to condemn governments for rendering services to people.

I think they should be criticized for not doing it, and especially now when we are faced with a very serious struggle in the world among the working people of this and other countries, Communists trying to destroy the confidence of people in their governments, in democratic governments. I think we ought to be rendering the services to eliminate that effective propaganda that the Communists are making, and I see in this health program a wonderful opportunity for our Government to establish the standards it should in the field of health, to help to provide the services, and in that way we meet head-on some of these arguments that are used trying to prove that democracy cannot work in the interest of all the people.

Senator TAFT. I agree that the health system in the States as drawn up, was not a particularly recognized Government activity. It was largely profit. The hospitals are, more than half of them, private. They were also recognized as the proper function of religious organizations, charitable organizations.

That system has grown like Topsy, and it is a rather uncoordinated system, but I think that in housing it is worse. Housing never came to be considered a matter for Government at all until very, very recently.

I do not think that was the fault of the States particularly. That was not the popular idea at the time, but it seems to me that we can stimulate those States with very little assistance. I think the actual system is a good system, with some gaps, and I think we can stimulate the States to improve their systems.

We started out with the hospital bill and I think as far as the construction of hospitals is concerned, it has had a very excellent effect on the States. I think all of them now have a plan and a coordinated idea as to what hospitals they want. I cannot see why we cannot extend the principle to other medical services. Of course, we have three or four other problems which we are proposing to deal with here besides the medical care angle.

Mr. CAREY. Senator, you understand my concern is that this belated activity on the part of some medical societies to do something is done for the purpose of avoiding enactment of legislation that has been found necessary.

Senator TAFT. I am not defending them. I am looking at it from a governmental standpoint.

I think if we can build up the State systems even if a few States fall behind, other States may well be better. If this is handled by the Federal Government and one official makes a mistake, that mistake applies to all 48 States. Then it takes a Hoover Commission to fix it, and then is does not fix it.

Senator MURRAY. Do you not think the American Medical Association was lacking in a study of the problem of medical education and the need for more doctors and more hospital personnel in this country? Until the situation has become so very serious that now we are frantically endeavoring to bring about a program which will enable us to provide more doctors.

Mr. CAREY. Senator, I would not deny that the medical associations and the profession itself has rendered tremendous service in the development of new methods in dealing with the ills of people, but they have not engaged in the kind of the programs that would translate those methods and those facilities to all the people.

We have today a situation in which the very rich can get the best of medical care. I do not think even the very rich get worth for their dollar in terms of what a mass production industry will provide in this country.. The very poor can get adequqate medical care, but by and large the large bulk of American citizens are not getting the benefit of the developments in the field of medicine.

It is not translated to them, and that is where it becomes very important. Some method of applying a treatment to an illness is a wonderful thing, but it is only wonderful insofar as it can serve the interests of the people and can be translated to them so they can taste the fruits of these great developments.

Senator MURRAY. Many of the medical profession of this country are taking enlightened views with reference to these problems, and are not in accord with the American Medical Association's opposition, arbitrary opposition to providing some kind of a national health program.

Mr. CAREY. Senator, we fully expect that the profession that is now opposing the action by the Federal Government in this field will, after it is adopted and in practice, become the foremost champions of this very program. That has been true in other areas of the world as well as here, particularly true in England, although their plan goes way beyond anything that is contemplated here, and the situation is quite different in terms of its size.

Senator TAFT. How does it go beyond it?

Mr. CAREY. Their system over there?

Senator TAFT. Yes. It seems to me this goes as far as it can go. What is the difference? How does England go further than the present proposed bill, 1679?

Mr. CAREY. I am assured by the authorities in England that they would welcome a committee of Congress over there——

Senator TAFT. You said that plan went further than 1679. I asked in what respect does it go further? It seems to me that 1679 goes as far as you can go.

Mr. CAREY. Their program there is much more comprehensive than this.

Senator TAFT. In what respect?

Mr. CAREY. In terms of the services rendered, in terms of the coverages.

Senator TAFT. It seems to me the bill before us is absolutely unlimited. It may be limited by regulation, but it is unlimited as far as the authority is concerned.

Mr. CAREY. Oh, no. The system is quite different. As I say, it would require a pretty thorough investigation. I was referring to the plan in England——

Senator TAFT. Of course the English provide other things, but I mean as fas as medical care is concerned, this seems to me to go as far in medical care as any system could go. In what respect does it not?

Mr. CAREY. Well, one respect is the extent to which the Government takes over control of the facilities of the profession. Over there they provide in addition to broader coverage, additional services in terms of, well, for instance, dentistry far beyond anything that we are suggesting here.

Senator MURRAY. They take over the hospitals there too.

Mr. CAREY. They take them over completely. Over there they provide you with glasses, they provide you with practically everything that is needed in terms of services and facilities.

Senator TAFT. Well, let me just read you what this one does.

Mr. CAREY. Senator, we could afford to have a better program and a more comprehensive program that England can, and the productivity of the American working people would support greater services by the Government than could be supported by the government there or in any other country of the world.

Senator TAFT. I am only interested in your suggestion that this is in some way limited and I suggest it is not limited. Personal health services include medical services, dental services, home nursing services, hospital services, and auxiliary services, which consist of—

> such chemical, bacteriological, pathological, diagnostic X-ray and related laboratory services; X-ray, radium, and related therapy; physiotherapy; services of optometrists and chiropodists; and prescribed drugs which are unusually expensive, special appliances, and eyeglasses; as the Board—

may by regulation prescribe.

I do not think there is any limit to what this bill provides.

Mr. CAREY. Senator, this bill does not provide the Government shall provide the drugs and chemicals for the care of the patient. In England in fact as I understand it they will proceed to go into the production by the Government of the drugs that are not made available at the present time.

Senator TAFT. We do not have to do that here. We can contract with people to make the drugs.

Mr. CAREY. I am fearful that you might put me in a position——

Senator TAFT. They are not actually manufacturing any drugs in England, as I understand it.

Mr. CAREY. They have already proceeded to do just that. They have proceeded, as I understand it. I have not been there for several weeks, and I do not go again for two more weeks, but the point I make there is that I talked to some of the doctors, some of the leaders of the organizations of the medical profession.

A few years back they were violently opposed to this program that they have in England. I talked to the same men after the program was in operation, and they are very able champions of the program, which indicated a complete reversal on their part of their attitude toward the Government's operation in this important field of the health of the citizens of the Nation.

Senator TAFT. That is not my story of the general attitude of the doctors in England. You say you have talked to some, but I have had letters. I put one in the record here from an English doctor last week, which took a very different attitude. He thought it was much worse afterward than before.

Senator MURRAY. Well, it would be very easy to provide dozens of other letters taking the exact opposite view. No doubt there is a lot of propaganda coming over from England to this country. I read articles in the papers almost every day trying to discredit the system over there, but the people of England seem to be entirely satisfied with it, and regard it as one of the finest things that the Labor government has put forth.

The doctors are cooperating. We have had representatives of the English Government over here that have told us that the plan is working out very satisfactorily.

Senator TAFT. Well, naturally they would say so.

Senator MURRAY. Naturally, those who are opposed to it will say that it is not working out, I guess.

Senator TAFT. The representatives of the Government would say it was working well.

Mr. CAREY. Senator, I would think it would be very natural for a member of the profession to change his attitude so radically. I think it had to be done, based on his experience.

Senator TAFT. I do not question that people change their minds. Some like the program and some do not.

Senator MURRAY. Here is an article I have from the Memphis Press-Scimitar of February 25, 1949, headed "British doctors praise new national health program."

> From the British Isles to the historic first National Cancer Conference have come these three men—Dr. Philip H. Peacock, of Glasgow, and Dr. Brian W. Windeyer, and Sir Stanford Cade, of London. Britain's national health plan is better than the old system, they agree.

These were representatives of the British Medical Society who came here to a conference in this country. During their stay here they were interrogated by reporters and they all defended the British system. I would like to have that printed in the record at this point.

On the back of that statement is a collection of excerpts from British medical publications and from other magazines. For instance, it has here a statement to the effect that the Lancet (long-established, independent British medical publication) has this to say:

> Both doctor and patient are pleased with their new and easier relationship. Patients are also grateful to observe that the new service is truly comprehensive. Complaints are few.

Now that is one of the most reputable medical publications in the world.

Here is a statement from the British Institute of Public Opinion:

> British voters named it the Attlee Government's best act. It far outranked any other measure in popularity.

Harper's magazine, in an article by John W. Vandercook, says:

> The most intense enthusiasm, all but un-British in its articulateness, is reserved for the last, latest, and greatest experiment of democratic socialism, the national health service.

That document will be included in the record at this point.

(The document above referred to is as follows:)

[From the Memphis Press-Scimitar, February 29, 1949]

BRITISH DOCTORS PRAISE NEW NATIONAL HEALTH PROGRAM

(By Robert Johnson, Press-Scimitar Staff Writer)

There are no more poor sick in England, nationalized medical care is working well, and physicians are not being penalized by England's national health bill, according to three eminent British men of medicine in Memphis as delegates to the first National Cancer Conference.

They are Sir Stanford Cade and Dr. Brian W. Windeyer, of London, and Dr. Philip H. Peacock, of Glasgow.

They did not defend their country's medical system, which was nationalized about 6 months ago. They actively advocated its merits, to an inquisitive, aggressive, and, on occasion, even badgering half-dozen of newspapermen covering the conference. They expressed their views cautiously and with qualifications, but their attitude was unmistakable.

Sir Stanford, who participates in the plan and still maintains his private practice, chuckled: "When I read your papers, I thought I was reading our papers when the question first came up."

Medical practice has not changed notably as the result of the bill, the Britishers said. The principal difference is that they send the bill to another office.

There are, of course, scoffers and critics. "There are a lot of people who don't like any change whatsoever," Dr. Windeyer said. And there are some who think their income has been interfered with.

There are "sharp corners" which have yet to be rounded, they said, and red tape is an increasing burden, but the plan will and must work.

The term "socialized" medicine is a misnomer, they said. It has nothing to do with party politics or philosophy. The bill was fathered by a liberal, Lord Beveridge, they said, and was introduced in Parliament by Winston Churchill. Churchill would have instituted the program had he continued in power, they said.

SOCIAL SERVICE ACTIVITY

It is "socialized" medicine in the sense that it is a social-service activity, they said.

Medical treatment is just one facet of a vast scheme. Each wage earner is compulsorily taxed from 4 to 6 shillings a week—from $1 to $1.50—and his expenses in many fields are taken care of—birth expense, funeral expense, and medical treatment among them.

With the British standard of living what it is, this has been expensive, they said. "Whether it will settle down to a level is problematical," Dr. Windeyer said. "I rather think it will."

There has been something of a rush for dentures and spectacles, Dr. Peacock conceded, and X-ray examinations have increased tremendously, but patients have not been calling the doctor out unnecessarily, as some critics in this country have said must be the case under such a system.

The medical men realized a necessity for a national health service, he said. The objections were directed principally at the methods of implementation of such a service.

As for income of the physician, Sir Stafford said: "It has not affected me adversely."

Scales and standards were set by a committee of England's most reputable medical men, they said.

MAXIMUM OF 4,000

A general practitioner wtih the maximum amount of patients permitted on his books—4,000—gets about $10,000 a year, but he has no expenses. The Government takes care of the overhead.

The scale varies with age, experience and professional competence of the physician, and his patient load. With 4,000 patients on his books, he does not treat all of them continuously. Most of them are well most of the time. It's as if one physician were caring for a town of 4,000.

The plan even provides for traveling expenses of persons in areas remote from treatment centers.

As to the criticism that with all expenses already provided for some would unnecessarily call the doctor, Sir Stafford said such cases are trivial.

"Some people will always call the doctor," he observed.

"People don't change very much as the result of legislation," said Dr. Peacock. "I don't think the people and the doctors are going to change very much."

MORE PAPER WORK

Sir Stanford said more paper work is unavoidable under such a comprehensive plan, and compared the service to that of the United States Army and Navy.

Dr. Windeyer said even the red tape has its advantages. "They will be able to gather more statistics," he said.

Sir Stanford said it is completely untrue that the plan has induced any tendency toward hypochondria. "The public has not abused the plan," he said. "And no person need now think that he is accepting charity when he gets the medical care which he should have."

The man with a middle-class income, who formerly had a hard go, has been benefited most, they said.

Certain critical forces have emerged, but "nothing's perfect," said Dr. Windeyer.

He said the future holds promise—centers for general practitioners, so they can take an afternoon off and still leave adequate practitioners to take care of their patients, for instance. This will have to wait until England has been able to roof its young married people.

Dr. Peacock said research is continuing just as before, with a substantial assist from voluntary contributions. A young man interested in medicine still pays his own way through school, and the demand for schooling in medicine is three times what can be taken care of, Sir Stanford said.

Early objections to the plan, Dr. Windeyer said, were principally based on an objection of physicians to becoming civil servants. They won this fight, and a doctor is free to join the service or not. Ninety percent have joined, they said.

"There is no shadow of doubt," Sir Stanford said, "that when the plan is fully working better medical treatment will be given the sick."

[From the Committee for the Nation's Health, Washington, D. C., and New York, N. Y.]

Is the British National Health Service Succeeding?

Paying doctor and hospital bills through health insurance is of great current interest to Americans. Here are first-hand reports from observers on the success of the British act.

Lancet (long-established, independent British medical publication): "Both doctor and patient are pleased with their new and easier relationship. * * * Patients are also grateful to observe that the new service is truly comprehensive. * * * Complaints are few."

British Institute of Public Opinion: British voters named it the Attlee government's best act. "It far outranked any other measure in popularity" (December 17, 1948).

Harper's magazine, John W. Vandercook: "The most intense enthusiasm, all but un-British in its articulateness, is reserved for the last, latest, and greatest experiment of democratic socialism, the national health service. * * *" (March 1949).

The Spectator (British conservative weekly): " * * * the new machinery seems to be running smoothly for both doctors and patients. * * * it obviously can be worked * * * and made one of which the nation may justly be proud" (October 1, 1948).

The Washington Star: "Despite difficulties, the national health service scheme has worked remarkably well in its initial stages * * * few serious criticisms of the health scheme have been voiced in the press or in Parliament, although its opponents originally predicted that the health service would be strangled in cocoons of red tape" (February 27, 1949).

Editorial research reports (serving America's leading newspapers): "Appears to command the support of both the professional groups and the British people" (January 12, 1949).

Francis Williams (editor, London Daily Mail, member of Parliament): "Has proved enormously successful and enjoyed by the middle class" (radio address, Station WEVD, March 11, 1949).

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BACKGROUND

The British national health service act, launched July 5, 1948, extends complete medical care to everyone. Like the national health insurance bill before our Congress, it provides free choice for both doctors and patients.

Both programs, while differing in some respects, spread and space the costs of medical care. Both work on the tested insurance principle of pooling resources to face a common risk.

The present British act goes back to the limited national health insurance act of 1912. The British Medical Association first opposed it, then repeatedly recommended its expansion.

Winston Churchill's government outlined the present act in 1944. The labor government passed it. After compromises, the BMA has cooperated in putting it into effect.

Senator TAFT. Do you think this bill presents in this country the "last, latest, and greatest experiment of democratic socialism," Senator?

Senator MURRAY. No; I do not think anything of the kind.

Senator TAFT. I thought you were denying it was socialism yesterday. Now you are quoting a paper that says it is the best experiment of democratic socialists.

Senator MURRAY. I am quoting the British article here with reference to the British system. The American system is entirely American based on the American insurance system.

Mr. CAREY. These programs are not peculiar to socialism. We have developed very fine methods and new techniques in this country, and I rather regret that there is so much credit given to socialism, and the Communists do the same thing. You would think the TVA was a socialist program if you read some of the stories that were written about it at the time the Government went into that operation.

Senator TAFT. I do not really object——

Mr. CAREY. I know you do not.

Senator TAFT. We are only talking about names. The TVA is socialism, of course. We have lots of socialism, but the question is how far shall we go. It was denied yesterday by the other gentlemen on the other side that this was socialism.

Mr. CAREY. It is no more socialism than the Taft-Ellender-Wagner bill. Your housing bill was called a socialist bill, too, Senator.

Senator TAFT. Of course it is socialism to some extent, but I do not think you socialize a practice if you only take care of those who are unable to pay. So you do not socialize housing if it is only for those people who cannot get decent housing.

Senator MURRAY. Senator, none of us have any objection to some socialism.

Senator TAFT. You socialized the educational system a hundred years ago. The question is, how far shall we go, how far can we go, without making it a completely socialistic state. It is only a question of degree.

Senator MURRAY. When they first proposed the system of deposit insurance in the banks of the country, that was denounced as a socialized program, and a socialistic provision, and it was bitterly opposed by many of the big bankers of the country. Yet it is in operation and it has worked satisfactorily and it has certainly been a good piece of socialized legislation?

Any other questions?

Senator TAFT. No.

Senator MURRAY. Thank you.

Mr. CAREY. Thank you, Senator. Thank you, members of the committee.

Senator MURRAY. Now the hospital association has some witnesses here this morning. I was going to suggest that we could have them make their preliminary statement, and then we could take a recess until after lunch for examination. If you are ready to go ahead, sir, you may proceed.

STATEMENT OF JOHN H. HAYES, CHAIRMAN, COUNCIL ON GOVERNMENT RELATIONS, AMERICAN HOSPITAL ASSOCIATION

Mr. HAYES. Mr. Chairman and members of the committee, the subject of health care for the American people is today the most widely discussed and perhaps the most controversial and important issue before the Federal Congress.

It [illegible] of all factions to improve the distribution of hospital and [illegible]are so as to make it available to all citizens no matter what their financial status or geographical location may be.

There is no more interested group in this subject than the American Hospital Association. Therefore, it is a great privilege for me to appear before you to express the views of these hospitals.

Health is not a simple subject. We in the hospital field, with many generations of experience in the admistration of health services, do not feel that any simple solution can be proposed that will cure everything. We do feel, however, that many of the proposals suggested to you involve great risk of producing far more harm than good. Therefore, the responsibility of our legislations to the American people becomes very great.

You gentlemen are like surgeons about to perform an operation on the Nation's health system. Your aim is to improve our existing system. But at the same time you must be aware that there is danger of inflicting permanent injury upon it. We might state that in this instance diagnosis can easily be made, but the choice of therapy is one requiring deep and long consideration so as to avoid the possibility of such therapy worsening the condition rather than improving it. By ill-considered action you could easily destroy the system which has developed the finest quality care in the world.

There is an even greater danger of preventing further growth and further development of the quality of care. Our health system today has grown naturally to meet the needs of the American people as they have been found to exist. It has been tailored to our standard of living and our scientific developments in science and medicine. We are justly proud of what we have accomplished. But, we are not through developing health care in this country. We have just begun an era of medical miracles.

We have added years to the span of man's life. In 1900 the average life expectancy was 49 years. Today it is 68; an increase of 19 years. We have brought about the lowest death rate in history. Testifying before the House Appropriations Committee in March 1949, Surgeon General Scheele reported that the death rate from all causes in 1948 is the lowest ever recorded in the history of our country. We have shortened the period of hospitalization. From an average hospitalization of 2 or 3 weeks in the early part of the century, the average length of stay for acute illnesses has been reduced to around 8 days. We have licked the killers that used to be important. Testifying before the House Appropriations Committee in March 1949, Surgeon General Scheele reported that in 1915 we lost 100 in every 1,000 babies before they were a year old. In 1948 this figure had been reduced to 32 per 1,000. The killers and cripplers which now confront us are the chronic diseases common to middle life. In 1948 diseases of the heart, kidneys, circulation, and cancer accounted for 60 percent of all deaths in this country. In 1900 the same group of diseases accounted for less than one-fourth of the deaths. Now we turn our attention to the diseases of old age, because we are saving people who would otherwise have died at an earlier age.

Our American system of free enterprise can be proud of these developments. The harsh incentives of supply and demand and competition for survival have made our people strong and healthy. We do not need to apologize for these great achievements in human welfare.

We must recognize that there is danger of crystallizing this progress and freezing it into a series of regulations and fix[illegible]ns in which growth might be impeded or prohibited. This is one of the grave dangers which you, as a surgeon of the Nation's health, must guard against.

It would be a far simpler matter to increase the quantity of care than to increase the quality of care. Unfortunately, any rapid increase in the quantity of care could easily affect its quality.

Progress is inevitable. The American people have found that health care is a procurable commodity. They demand that this care be made available to them, not only in the urban centers, but also in rural communities and in sparsely settled areas. In assisting in the distribution of hospital and medical care, government, as a tool of society, has a responsibility which is unavoidable. We now recognize that local, State, and Federal governments must face up to this responsibility. That's why we're here today.

Our problem is to obtain wide distribution of health care without destroying the quality of care as we know it today. It must be done without preventing further progress in the improvement of that quality. It is also desirable that we accomplish this distribution without waste of money or manpower. We have reached the point where we realize that the Federal Government does not have unlimited funds. We who have had to cope with deficits over many decades perhaps realize more than others the danger to our Government in the failure to reduce the national debt.

We further realize that there are definite limits to taxation, as we have found that there are definite limits in the amount of philanthropic help we can secure. We further realize that heavy taxation seriously affects philanthropic support of hospitals. We should examine the situation carefully before we establish another bureaucracy which could make all of our existing systems look small.

Besides, our health resources in this Nation are limited. We must not waste them. There will always be more health problems than we can completely take care of—the problem of health is never really solved. Therefore we must organize our existing resources so as to use them in the most efficient possible way.

Government has already assumed major responsibility in the operation of hospitals for our mental cases, tuberculosis and chronic disease, and other long-term care. For veterans, armed forces, merchant marines, and Indians, separate systems of general hospitals are in operation by the Federal Government. The Hoover Commission made a special study of the health activities of the Federal Government. The findings of that Commission should be considered by this committee. They are most interesting.

At local level, government has also assumed responsibility for providing care to persons in communities who cannot pay the full cost of it. Usually it is State or local community government which undertakes this responsibility. It can be met by building special charity hospitals in which so-called free care is given. Or more often, local government purchases care from the existing voluntary hospitals in the community.

The experience of government in providing hospital care shows that even government has not mastered all of the problems. See Hoover

Commission Report on Medical Services of the Federal Government.

Since these voluntary hospitals are dependent upon charitable contributions and endowments and gifts from the communities which they serve, it has developed that hospitals are acutely responsible to the needs of the communities. In other words, the hospital administrator has a responsibility that is broader than simply managing a hospital.

The hospital, of course, does not in itself render medical care. Rather it organizes care. It brings together all of the expensive equipment and the highly trained personnel which may serve the doctor in effecting a cure. As medical science has developed, hospital care has become more complex. The hospital is a workshop. If it is to turn out a good product, it must be equipped with the machinery and personnel it requires. But the organization of this complex service is only part of the hospital administrator's job.

The hospital must serve the whole community. Into the community hospital comes a cross section of all of the citizens of the community—rich and poor, those who are able to pay, those who have protected themselves by voluntary health insurance, and those unfortunate few who have not been able or farsighted enough to make provisions in advance, as they do in so many other forms of insurance where losses might affect them financially. From dealing with all of these groups, the hospital is acutely aware of the problem of distributing care to the whole community. It is for this reason that I have said that the hospital administrators of the country have for many, many years faced this problem which is just now coming to the attention of the Congress.

The thinking of the hospital field, based on years of experience in providing hospital care on a community-wide basis, was crystallized in a resolution adopted by the house of delegates at the annual meeting of the American Hospital Association in October 1944. In that resolution a three-point program of action was recommended.

1. MORE HOSPITALS

As point No. 1 we recommended Government aid for public and voluntary hospital construction upon evidence of unmet needs. The Hospital Survey and Construction Act which was enacted in 1946 by the Congress was a recognition of this need. Already nearly 800 hospitals have been approved by the Surgeon General for construction with Federal assistance under this Hill-Burton program. Hospital leaders have worked closely with the Federal agency and with State agencies in making surveys and developing State programs.

It will be a long time before the total deficit in hospital facilities is met in this Nation. However, we are closing in on that deficit from both directions. The length of hospital stay has been greatly reduced. Also, it must be noted that under the Hill-Burton program most of the hospitals are being built in small communities where good care may be brought to more people.

It must be borne in mind that skilled personnel must be trained and made available for the staffing of these hospitals. We will later submit to this committee a detailed statement in regard to some of the legislation before you providing for Federal assistance in the training of health workers.

It should also be noted that hospital construction in this country is not limited to that being carried on with Federal assistance. Hospitals are being built in every corner of the Nation by communities independent of Federal assistance. The people have not waited for the Federal Government to take the leadership in hospital construction.

The American Hospital Association has already presented testimony before a subcommittee of the Senate Committee on Labor and Public Welfare supporting an expansion and extension of the Hill-Burton Act somewhat as it is embodied in S. 614. Further, before the same subcommittee the association has testified in support of S. 522 providing for aid to the States extending full-time public health departments.

2. VOLUNTARY PREPAYMENT PLANS

Point No. 2 was extension of voluntary budgeting for the cost of medical and hospital care. The American Hospital Association has been the leader in the development of prepayment plans for providing care to persons able to pay premiums. When hospital insurance plans began to crop in in various parts of the Nation nearly 20 years ago, the American Hospital Association determined that this movement should be directed so as to serve the people on a nonprofit basis.

Following a study of the problem, a committee of the American Hospital Association was established to set up approval standards. Over the years this committee has grown into the Blue Cross Commission of the American Hospital Association. The approval standards of the American Hospital Association are a guaranty that any plan for prepayment of hospital care which carries our Blue Cross seal of approval is organized for service to the community. The Blue Cross plans are independent, autonomous corporations established in 90 communities of the United States and Canada. They are nonprofit organizations. They are directed by boards of trustees who must be drawn from all segments of the community with public as well as medical and hospital representation. A majority of the hospitals of the area must participate in the plan and guarantee the services promised in case the plan itself should become insolvent. Blue Cross plans are set up to pay out in hospital service, not in dollars.

It is interesting to note that in 1939 when compulsory health insurance was first proposed in Congress, these Blue Cross plans provided protection to only 3,000,000 people. Today more than 33,000,000 persons are protected by Blue Cross. Another 19,000,000 have commercial insurance policies providing some measure of hospital protection and nearly 10,000,000 have enrolled in Blue Shield plans for prepayment of medical care within recent years. It has been estimated that more than 52,000,000 have already purchased some sort of voluntary health insurance. When it is considered that there will always be a part of the population unable to take care of its needs whether such needs be in shelter, clothing, food, or health care, and another proportion in our prosperous country able to take care of these needs even when unexpected, I believe that this progress is most commendable.

We are proud of the part of the American Hospital Association in developing the Blue Cross plans. We recognize that these plans have been developed to meet a social need. We believe that the public acceptance of Blue Cross plans—nearly a quarter of our population is enrolled in Blue Cross—is an indication that the voluntary prepayment plan has an important part to play in the distribution of health services in the Nation.

Senator Taft. You heard the testimony just now of the Blue Cross plan which costs $2.50 a month and gave 1 month's hospital care. Is that typical of Blue Cross plans?

Mr. Hayes. They run 21 days. I believe there are a couple of plans that run as high as 60 days. The new compulsory health bill, I believe, limits it to 60 days, but Blue Cross in general averages to about 30.

Senator Taft. What bill limits it?

Mr. Hayes. 1679 limits it to 60 days. I bring out that point, Senator, because Mrs. Hilton would have had only one more month paid under the Government plan, and she would still have had all these months.

Senator Murray. Under 1679 it begins with 60 days, but is to be extended as the facilities are developed.

Mr. Hayes. Well, the way the bill is today if it were enacted she would have only 30 more days. She would still have had a good many hundreds of dollars of expenses.

Senator Taft. This $2.50 a month is for 30 days. Can you buy 60 days or any length of time you want?

Mr. Hayes. No; the contracts are uniform.

Senator Taft. Each one has a uniform contract? It is different in different States, though, is it not?

Mr. Hayes. It varies in the amount of benefits, and sometimes the service.

Senator Murray. And sometimes there is a limitation on the income.

Mr. Hayes. Not in Blue Cross, sir. In Blue Shield it is, but not in Blue Cross.

Senator Taft. May I ask this? Why should not catastrophe insurance of some sort be furnished, I mean to meet the case like the Hilton case. In all insurance you can go up to 100,000 limit on accident or 200,000 liability insurance, and of course that is the kind you want, and it is pretty cheap, as a matter of fact, because it happens so seldom that it does not cost much more to do it in the case of automobile accidents. Most people think it pays to get the extra insurance to prevent the really extreme case.

Mr. Hayes. Your thought is Blue Cross might have, by payment of a special premium, an extension of the time?

Senator Taft. Yes; even if they extended their time to 6 months, I do not see that there would be very many cases of additional expense. I do not know what your proportion is, but the suggestion that I made, I think there must be a very small proportion of people who are hospitalized for any special illness for more than 30 days or more than 60 days.

Mr. Hayes. That is true. The average length of stay today perhaps is 10 days throughout the country.

Senator Taft. It is an average way below that.

Mr. Hayes. That is why a great many Blue Cross plans have in recent years increased their limitation of 21 days up to 30 days, because in their calculation they figured it meant so little more they did not even have to increase their premium. The same thing would apply even perhaps in greater proportion if they increased it to 60 days.

Senator MURRAY. Have you studied the Kaiser hospital program?

Mr. HAYES. The Kaiser plan is similar to a great many of the plans principally in the western part of the country of group practice of medicine. Yes, sir; I know quite a bit about it.

Senator MURRAY. I understand that they give very extended hospital service. They give 3 months.

Mr. HAYES. I do not know exactly how long it is, but it is longer than the Blue Cross plan. Of course it is a higher rate of insurance, too. It is all based in with the medical.

Senator MURRAY. I understand it is only a very small deduction from the pay roll of the workers and furnishes complete coverage for the worker and the family.

Mr. HAYES. But does not Kaiser then pay the deficit?

Senator MURRAY. Yes.

Mr. HAYES. Well, that is the point.

Incidentally, proponents of compulsory health insurance are vague as to the part which Blue Cross and other prepayment plans would perform in the event the Federal Government took over the entire system. The experience of the Blue Cross plan in British Columbia may be taken as an indication. When a compulsory hospital insurance law was enacted recently in the Province of British Columbia, Canada, the Blue Cross plan in that Province went out of business. The premiums for the Government plan were supplemented by general taxes, just as is currently being discussed by proponents of compulsory health in this country. (The short experience in England has already shown that the pay-roll deduction represents only a small part of the actual cost, and it must be admitted that whether or not deducted from the pay roll, such costs are paid by those who work.) Thus the compulsory health-insurance program in British Columbia was made to look cheaper than the voluntary plan because of the hidden subsidies from general taxes. It is thought that the enactment of such a system in this country would either force the Blue Cross plans out of business or limit them to carrying special types of risks.

3. GOVERNMENT RESPONSIBILITY FOR CARE OF THE NEEDY

Point 3 of the American Hospital Association recommendation was the assumption by Government of the responsibility for the provision of care to persons unable to pay for it. Society has always been responsible for its unfortunate citizens. Society meets this responsibility either through government or voluntary agencies. Voluntary hospitals have carried a tremendous amount of this burden in this country. In 1947 a survey of the American Hospital Association showed that on the average patients paid hospitals about $1 per day less than it cost the hospital to provide that care. This does not include the cost of depreciation on the buildings and equipment.

The difference, of course, was made up by voluntary contributions, charitable gifts, and endowments to the hospital for care.

But as government has increased in size and activity, it has added tremendously to our tax burden. Further, while charitable contributions have not substantially decreased, and in fact, in many instances have grown in size, the severe inflation which is on us has increased cost at a rate far greater than has been followed by any increase in charitable giving.

Perhaps it is inevitable that society should turn to Government as an alternative agency for carrying part of its responsibility for providing hospital and medical care to the needy. As a matter of fact, Government has always acknowledged this responsibility but has seldom met it fully. In practically every locality, in every State of the Union, at least some provision has been made for Government responsibility for persons unable to pay the full cost of their care. Sometimes local government builds and operates a "chairity" hospital. More often community government provides funds for the purchase of hospital and medical services at Government expense.

A recent survey of one of the committees of our association shows that there are almost as many patterns of providing care for persons unable to pay for it as there are States and communities. The common denominator of most of these patterns seems to be inadequacy. Often, the State or community does not appropriate sufficient funds to provide care throughout the year; this results in exhaustion of the funds by midsummer or early fall with no provision of care for unfortunate citizens in the latter part of the year. Frequently, the community establishes such a low rate of payment to hospitals that the full cost of care is not provided. Thus an added burden is imposed on the charitable funds of the institution. Also, it is a well-accepted fact that the States have not provided sufficient funds to give adequate care for mental, tuberculosis, and other chronic, long-term illnesses which are generally accepted to be their responsibility.

As one bright spot in this situation, the nearby State of Maryland has made excellent progress in a State-wide program of hospital and medical care for its indigent. A recent study of this program has been written by Mrs. Agnes Meyer and published in the Washington Post. It is hoped that your committee will examine the Maryland program as an example of what States can do for themselves in meeting their own health problems.

It should be noted that the Blue Cross plans have brought hospital care within financial reach of large numbers of our citizens who would otherwise be classified as indigent. A combination of Blue Cross and Blue Shield protection can be purchased for an entire family for an estimated $5 to $7 per month. When compared with the amounts paid for tobacco, cosmetics, amusements, automobiles, et cetera, this is surely a pittance. Our people are insurance conscious, and they are availing themselves of the opportunity to obtain Blue Cross protection just as rapidly as it can be made available to them.

Incidentally, we observe that the compulsory health insurance program does not propose any assistance for persons unable to pay for care. Let me quote you a sentence from section 705 (a) of S. 1679, the compulsory health insurance proposal:

> Any or all benefits provided under this title to individuals eligible for such benefits may be furnished to individuals (including the needy) not otherwise eligible therefor, for any period for which equitable reimbursements to the account on behalf of such needy or other individuals have been made, or for which reasonable assurance of such reimbursement has been given, by public agencies of the United States, the several States, or any of them or of their political subdivision, such reimbursements to be in accordance with agreements and working arrangements negotiated with such public agencies.

Do you notice that under this provision the Federal Government would provide no assistance whatever in financing care to these unfortunate people for whom the need is greatest? The entire burden for the indigent would be left upon the States and local communities under the compulsory health-insurance program, plus the added costs of Federal administration. If the States and local communities did not pay premiums into the Federal Government, these needy individuals would receive no protection.

Senator TAFT. It was testified by the Assistant Federal Security Administrator that the general-assistance bill in the House provided Federal money for that purpose on some matching basis, I think, but I have not heard that the House has done anything about it.

Mr. HAYES. Like your bill, Senator.

The compulsory health-insurance program would only provide care for the persons now receiving it. It would not provide care for those who need it most—those who are not able to pay for it.

Senator MURRAY. It provides a method, though, whereby the State or communities responsible for those people who are unable to pay anything——

Mr. HAYES. Well, the States and communities have to a large degree accepted that responsibility, not to a full measure.

Senator MURRAY. They do not get the kind of service they need. They get very poor service.

Mr. HAYES. In spots they do.

Senator TAFT. But they can do that without our permission, can they not? We do not have to authorize them to do that.

Senator MURRAY. It is not authorizing them to do it, but it permits them to contribute the amount of money that they are already contributing for that purpose, and have them taken care of through the system that is being provided.

Mr. HAYES. With some Government help, you mean, to do it.

Senator TAFT. They do not get any Federal money.

Mr. HAYES. No. That is the point. I mean they are in no different position than they always have been, Senator.

Senator MURRAY. Except that they get better service.

Mr. HAYES. Well, I do not know. I would not agree to that statement that they would get better service.

Senator MURRAY. Because at present it is sort of a haphazard system that does not provide adequate care for the indigent. They only are able to get in there when they are in desperate condition, and sometimes they come from the ranks that are self-supporting.

Mr. HAYES. That is right.

Senator MURRAY. They get in a situation where they cannot go any further, and then they become charity patients.

Mr. HAYES. Would that increase man's humanity to man? I cannot see it.

Senator MURRAY. What is that?

Mr. HAYES. That would not create any change in our present system of States and communities——

Senator TAFT. They have hospitals and doctors they can employ today. The trouble is the States do not employ them. Now they say they can employ the Federal Government and there is no evidence the States would employ them, either. I do not see any change in the treatment in this bill.

Mr. HAYES. I do not see that that would be helpful in this direction.

Senator MURRAY. You would prefer to have the system go along as it is now in the different States and communities.

Mr. HAYES. In the development of voluntary plans, yes.

Senator MURRAY. Well, how are they going to get in on a voluntary plan?

Senator TAFT. We are going to give them $300,000,000 a year to improve that service.

Mr. HAYES. They will not be paying any insurance to the Government either. If they are from workers and others, they will not be paying the Government, either. They will not be insured under 1679.

Senator MURRAY. They are permitted to come in under the provision of the bill by making payments and may become insured the same as the others.

Mr. HAYES. Do you believe they would have any greater incentive than they have now? They can come into any voluntary plans.

Senator MURRAY. The voluntary plans are too expensive. They do not give them complete coverage. They do not give them adequate hospitalization, and there are many other defects and deficiencies in the Blue Cross plan.

Many people cannot afford to take it, and then when they do take it, they do not get complete protection.

Mr. HAYES. Well, in most of the plans it is complete protection in semiprivates. It was originally set up for the group of people that we felt did not get the care.

The rich people got it and the very poor people got it, but the middle class, who had their pride, did not, and that was the reason for setting up Blue Cross and making it available to them on a nonprofit basis, and something that they could pay for at a rate, as I stated, which is less than they pay for cigarettes, as Dr. Hawley said yesterday.

Senator MURRAY. Well, we will cover that situation later.

Mr. HAYES. If we had to say that all of our problems are solved, the possibility of future improvement would be very dark. We shall always have a health problem. We must always direct our programs toward improvement with the realization that any promise of complete cure is false.

Thus we recognize that the Hospital Survey and Construction Act is still in the process of providing more hospitals in communities where need is greatest. Under the Blue Cross Commission of the American Hospital Association, the voluntary prepayment plans are in the process of developing protection upon which the average citizen can depend. It is upon the basis of continuing growth and development of our health system that we make our recommendations.

At the present time we believe the most important aspect of our health program and the one needing most immediate attention from Government is the matter of providing care to persons unable to pay for it. We believe that an excellent step in this direction is outlined in S. 1456 which was introduced in the Senate by a bipartisan group of sponsors.

The American Hospital Association has devoted a great deal of attention to S. 1456 in an effort to understand what it would mean with respect to the problem of providing care to the whole population. We believe that S. 1456 is in general keeping with the principles enunciated by the house of delegates of the American Hospital Association and we support this legislation because it is directed to meet the precise need which now exists.

It will not destroy our existing voluntary system of providing hospital and medical care. It will preserve the freedom of doctors and hospitals to provide the best care they know how to their patients. It will preserve the freedom of our voluntary system to grow and improve the distribution of hospital and medical care to the people. It will be more efficient and less expensive than any other solution that has thus far been proposed. It will encourage the development of local administration to meet local community needs with a maximum of freedom from Federal control.

Persons who are now protected by voluntary health insurance are able to go to the hospital or doctor of their choice and present their service contract card as evidence of their protection. The voluntary health insurance bill proposes to make this privilege available to those who are not able to pay the full amount of the subscription charges. It would then be possible for every person in the Nation who desired it, to have a service card of a prepayment plan. He might pay the entire subscription cost, but if he were unable to pay the full amount, the Government agency might make it possible for him to pay part of the subscription charge or, perhaps, provide the protection free.

Probably at least 75 percent or 80 percent of our population could afford voluntary prepayment insurance. The average cost of such protection is only $5 or $7 a month. However, in this Nation we do not believe in compelling people to do what they do not want to even if it is good for them. (As a matter of fact, the American Revolution was fought against the imposition of a tax which people did not want to pay.) We furiously resent the efforts of "do-gooders" to impose upon us impractical patterns of behavior.

We do believe, however, that programs of public education and promotion could well be carried on by State and local governments to improve the enrollment of the population in existing voluntary plans. In many of the States, a substantial proportion of the population is already enrolled. Blue Cross plans have sponsored community enrollment during which membership in the plans are open to all citizens of the community. This is being rapidly extended by all the Blue Cross plans.

It will be recognized that there will always be some persons in the population who will not afford themselves with adequate protection until a crisis is upon them. However, it is not desirable to upset the system which is providing care satisfactorily to the largest portion of our population simply to prevent the system from being abused by a few improvident individuals. Instead, we believe that the force of public opinion and programs of public education can develop a sense of responsibility in these individuals. Individual responsibility cannot be developed through programs of compulsion nor through programs which appear to promise something for nothing.

Senator MURRAY. What programs have you in mind that promise something for nothing?

Mr. HAYES. What programs?

Senator MURRAY. Yes.

Mr. **Hayes**. Well, perhaps the word "nothing" should be "promise something for a great deal less than its cost."

Senator **Murray**. You wish to change your statement on that. I do not know of any program that offers something for nothing.

Mr. **Hayes**. No; that is so.

In developing voluntary enrollment in prepayment plans, the voluntary health insurance bill proposes that there should be emphasis upon employer participation in the transmission of subscription charges. In providing Blue Cross protection to large working groups, employers of the Nation have provided a substantial contribution to labor-management relations. There is considerable expense and inconvenience in deducting the small monthly premiums from the pay checks of employees and transmitting it to the prepayment plans. American employers have usually been happy to do this as a contribution to the welfare of their employees. We think that inadequate recognition has been given to employers for the service they have provided in making it possible for employees to protect themselves in this manner. Many labor unions now are urging the inclusion of hospital and medical benefits at the employers' expense and such provisions are in many labor contracts. Also, such welfare funds have been created by employer groups with their workers protecting against hospital and medical costs.

We would like to point out that the Federal Government, as the largest single employer in the Nation, has set a very poor example of labor-management relations in its refusal to allow its employees to purchase voluntary prepayment care through pay-roll deductions. It is indeed true that this would represent some administrative expense to the Federal Government. However, there is already a considerable amount of hidden expense in the situation as it exists today. In many departments of the Federal Government, minor employees are spending a certain amount of time at taxpayers' expense in the collection of Blue Cross premiums simply because the administration has not been able to recognize a simpler way of doing it. For instance, in testimony before the Post Office and Civil Service Committee of the Senate early this year, employees of the Federal Government in Washington testified that they spent substantial portions of their working time 1 or 2 days each month in the collection of monthly premiums for prepayment protection plans.

We strongly favor the provisions in the voluntary health insurance bill which would require Federal and State Governments to permit their employees to have pay-roll deductions for subscription charges in voluntary prepayment plans. We understand that the compulsory health insurance bill would not cover the employees of Federal, State, or local governments though we firmly believe these groups are entitled to protection.

In the last Congress, we testified in favor of Senator Taft's provision for Federal employees and we renew our approval of his proposal in S. 1581 and the same provision in S. 1456.

We firmly believe that no central administration should dictate the basic pattern of health services in local communities. Local health services should be responsive to local needs as far as possible. Even the proponents of the present compulsory health insurance proposals recognize this basic principle when they speak of decentralization of authority, although a close examination of S. 1679 shows that local authorities would be subject to extremes of Federal regulation and control.

S. 1456 proposes a pattern of regional administration which is well worth studying. It would gather together all of the groups concerned with provision of health services in the community. These would be representatives of nongovernment organizations or groups, State and local agencies concerned with the utilization of hospitals including representatives of medical associations, hospital associations, voluntary prepayment plans for hospital and medical care and representatives of the consumers of hospital and medical care. Such groups must work voluntarily together in the common purpose of providing a better distribution of our existing services. The regional groups provided in S. 1456 would be an excellent starting point.

In this connection, it should be noted that the amendments to the Hospital Survey and Construction Act, which are contained in all three of the proposals before your committee, would provide funds to the Public Health Service for studying the integration of hospital and health-center facilities. This is one important aspect of the American Hospital Association program. We favor the extension of interhospital coordination and cooperation both urban and rural. Under the hospital survey and construction program, most of the States have already been divided into districts which, in the ultimate scheme of things, ought to include complete hospital and health facilities. The voluntary health insurance bill would provide that these divisions might be followed in the establishment of regional health authorities. If we believe in the provision of care with complete local control and coordination, these are the organizations which must be developed to bring about the most desirable result.

The regional authorities under the voluntary health insurance bill could act as units of the State agency in certifying individuals for eligibility to receive part or full assistance in the payment of subscription charges for prepayment protection. It is probable that the State might establish methods of coordination of existing facilities in order to develop uniform patterns within the State. But it should be noted that this prerogative belongs to the State. There is a minimum of Federal regulation under this bill. Maximum freedom is permitted to the States and to these regional authorities to coordinate their local resources to fit local needs.

Voluntary cooperation is not a pattern which can be centrally established and imposed upon the country as a whole, by any compulsory program. Ours is a vast country with many differing groups of people for whom no single pattern can be developed which would be satisfactory to all.

The American Hospital Association, in reading through the provisions of S. 1456, assumes that any eligible individual may qualify, at any time, for assistance in obtaining hospital and medical-care prepayment protection. Thus he might apply at any time for assistance in the payment of full or part premiums for protection of himself and his family. He would make this application locally where his need would best be known. He could apply for this assistance at time of illness. But he would be encouraged through programs of education and promotion to make application in advance of need. Thus the embarrassment of a means test at the time of illness would be avoided. And by making this a voluntary program, it would be possible for individuals to avail themselves of this protection or not—as they chose.

The service card of the prepayment plan would assure the individual or his dependents of the same hospital and medical services now provided to persons who pay their own way without any indication to the doctor or to the hospital that the individual is receiving assistance. The service card would not be identifiable by the hospital or the doctor. The prepayment plan would identify the contract card by number and bill the Government for services rendered. Thus Government control of services would be avoided.

This raises the question of possible abuses. These depend largely upon the discretion of doctors and others who control the incidence of hospitalization and length of stay of individual patients. It is noteworthy that under Blue Cross so far there has been a minimum of abuse or overuse of services. This is in contrast with the English system where doctors have been overrun by patients striving to obtain their "rights." The absence of abuse is inherent in voluntary systems, and it is one of the most difficult things for Government administrators to understand.

The voluntary system would also avoid the frequent criticism of governmental efforts which too often provide a separate quality of care to persons who receive it as a measure of charity. Since the individual receiving care would not be identified at the time of service as a recipient of assistance, he would receive the same quality of care as any other citizen. Likewise, he would be as equally entitled to complaint. The effectiveness of direct complaint is an important factor in the maintenance of the quality of care.

The American Hospital Association has noted with approval the limitations which have been established on the care to be provided under the voluntary health insurance bill. In the first place, individual home and office calls have been excluded. There is no sense in sending money to Washington and paying large administrative costs to have it sent back and paid to doctors for the comparatively small incidental expenses which can usually be taken in stride by the average American citizen at far less expense. Average people can afford occasional home and office calls. It would be too expensive to establish a large bureaucracy, requiring doctors to fill out prescriptions in quadruplicate with reports by hospitals and pharmacists, et cetera, for a large volume of incidental calls.

This is what has placed the greatest burden on the English system. As a matter of fact, it has frequently been said that it is desirable to have a financial barrier between the patient and the doctor so that the patient will not be tempted to abuse these services. Perhaps it is closer to the truth to say that the real need is not in the small items. The place where the American citizen wants relief is against the larger expense of a prolonged hospital stay and a high doctor bill, as did Mrs. Hilton. This is provided through voluntary health insurance.

The 60-day limitation on care likewise seems desirable. This, incidentally, is the same limitation that appears in S. 1679. Beyond that period of stay the States and communities have responsibility for the provision of long-term care. These studies might lead to recommendations for later changes.

We also approve the limitation of care to that provided in short-term hospitals or diagnostic clinics. Until the surveys of long-term care can show the desirability of modification, it is well to take one step at a time. It is too easy to make wild promises. However, the sensible American is usually suspicious of programs which promise too much. We believe it is more reasonable to promise what can be delivered and keep making steady progress.

When a man is unemployed is when he and his family are in greatest need of health protection. The unemployment compensation provisions provide some measure of relief which would help to maintain food and clothing expense. But it does not provide enough to pay subscription charges for health and medical care protection. Usually, if he has been making these payments from a pay-roll deduction plan, he may, if he wishes, continue making them directly to the prepayment plan after separation from a pay roll. However, as a rule, very few persons do this because of the sudden failure of income.

The voluntary health insurance bill provides that during a period of unemployment the subscription charges for hospital and medical care prepayment protection will be maintained by the State agency in addition to unemployment compensation. By contrast, the compulsory health insurance proposal does not afford this protection. The implication is very strong in S. 1679 that when no wage deductions are being made for the employee at the pay-roll source, his protection under Government assistance ends. We submit that this is the time when such protection is most needed. We strongly favor this provision in the voluntary health insurance bill.

While acknowledging that there are many problems which need to be solved in our health system, the voluntary health insurance bill does not presume to promise to cure them all. It acknowledges that additional information is needed before further steps can be taken.

The voluntary health insurance bill provides assistance to the States to examine their own problems and to develop methods for solving those problems, themselves. Some Federal aid may be necessary. But it should not be our purpose to attempt to do something for the States which they should do for themselves.

The voluntary health insurance bill proposes aid to the States in surveying four major problems. We are pleased to note proposed similar assistance in S. 1581.

The importance of proper diagnosis is primary in health and medical care. Where hospitals used to be essentially curative institutions they are now recognized as important centers of diagnosis. The development of expensive equipment and elaborate laboratory processes for diagnosis has made hospitals vital in this field of health care. We believe that in providing funds to the State for surveying existing diagnostic facilities, steps can be taken toward early recognition and treatment of illness.

The voluntary health insurance bill provides that Federal aid shall be available to the States to survey their existing facilities, services, and finances for care of mental, tuberculous and chronic disease and other patients hospitalized for long periods of time. These are recognized State problems. Frequently the States meet the problems inadequately. This legislation would make it possible for the State to understand its problems and to develop plans for meeting them. Many of the States have already faced up to the problem of long-term care and are taking great steps toward improving their situation. Offering Federal aid for such surveys is good. But Federal aid for improvement should be withheld until it is found that the need can be met in no other way. The development of State plans for meeting the problem of long-term care will be a long step forward.

The voluntary health insurance bill offers assistance to the States in surveying areas which are financially unable to attract physicians. There have already been proposals in Congress to subsidize students in schools of medicine and require them to practice in rural or needy areas for the first few years in repayment of loans. The Hospital Survey and Construction Act will encourage doctors to settle in such areas by bringing hospital facilities closer to these people. As a matter of fact, some attention might be given to encouraging cooperative organizations if such programs are favored by citizens of the area. This is essentially a State problem. The States should be assisted in studing their needs and developing plans. However, Federal aid of the problem should be limited to what is shown to be necessary by these surveys.

Many States have substantial percentages of their population enrolled in voluntary prepayment plans for hospital and medical care. Commercial insurance companies have recently developed considerable activity in this field. It is the feeling of the American Hospital Association that individuals should be free to choose the kind of protection they pay for. Under compulsory health insurance, people would have to pay a tax, whether they wanted to or not—even if they preferred a different sort of system. However, we believe that the State government, with Federal assistance, might look into the matter of encouraging its citizens to purchase protection. Programs of education and encouragement are preferable to programs of compulsion.

In this connection, it is important to remember that the Blue Cross plans are service organizations. They are not self-interested nor do the hospitals have a selfish interest in them. Hospital and medical care protection is largely a nonprofit field. The aim of both types of organizations is to provide service to the entire community. The Blue Cross plans have been supported by the American Hospital Association because they conform to standards of community service which have been established by hospital people who are themselves aware of community needs. On the other hand, where commercial insurance performs service to a broad group, it should be worthy of equal consideration.

In discussing surveys generally, it should be noted that the absence of Federal assistance in meeting needs which may be discovered by the surveys is unusual. Yet we should place maximum emphasis on encouraging the States to meet their own problems. This is not only less expensive and more efficient; it also brings about the desirable maximum of local participation. Federal aid should be provided only if necessary to stimulate and encourage. We often forget that the Federal Government should not aim to supplant the States in functions which are primarily State responsibilities.

We have already pointed out that the regional authorities bring together all of the groups within the local area who are concerned with the problem of providing hospital and medical care to the community. We have pointed out that the areas in which these regional authorities might act have probably been already established under the Hill-Burton Act.

It is important that each of these areas should be encouraged to meet their own needs to the fullest extent possible. However, in discussing Federal administration it will be seen that some uniform standards and broad guides are necessary. In the voluntary health insurance bill these are made as general as possible. Our concern is that the guidance given to regional authorities should allow the broadest possible latitude in developing methods of meeting their own problems.

We approve the requirement that the State must assure that Federal funds will be used in addition to any program the State is presently carrying on in this area of need. We do not believe that any Federal program should simply permit the State to shift its existing burdens. The purpose of this program should be to encourage expansion in the programs for distributing health and medical care to persons in the State.

We also note with approval the maximum of authority given to State agencies and the great freedom of State agencies from Federal control. Under the Hospital Survey and Construction Act we have seen State agencies use their maximum of State authority to develop excellent cooperation among Government agencies and voluntary agencies in achieving this common purpose. We favor the opportunity which is given in the Voluntary Health Insurance Act for vigorous State action. As a corollary we favor the smaller degree of authority which is provided to the Federal agency.

We note with approval the composition of the Federal and State Hospital and Medical Care Councils. This will bring in groups who are concerned with and experienced in the provision of hospital and medical care through prepayment plans. It will also bring in representatives of the general public to be sure that the program is designed to serve all of our citizens.

We particularly favor the degree of authority which has been given to the Federal Hospital and Medical Care Council. This is the same pattern which has worked so excellently under the Hill-Burton Hospital Survey and Construction Act. Under this pattern of authority the Federal Hospital Council has been of genuine assistance to the Surgeon General in developing programs which have been well received by State agencies and voluntary agencies with a minimum of Federal dictation. As a matter of fact, it is our belief that the Federal agency has been able to accomplish more through the cooperation obtained by this type of authority than it could have obtained by centralized dictation and arbitrary regulations imposed by one individual.

In establishing Federal regulations which are, of course, necessary in maintaining essential uniformity of a Federal program, we are pleased to note that regulations are limited to six specific areas. We note that the regulations are to be very general and not detailed in content. We note that these regulations are apparently intended to be more for the guidance of State agencies than for the control of State programs.

It must be recognized that it would be very difficult to imagine at the Federal level all of the patterns which might be developed within separate States. A maximum of freedom is to be desired if we are to have the advantages of variability and experimentation. We have not yet arrived at the point where we wish to crystalize any single pattern and say "This cannot be improved." The advantage of any voluntary system is its ability to grow and develop and to adapt itself to meet the changing needs of our people.

In summary, the American Hospital Association in general favors the aims of much of the legislation being considered by your committee. We have testified in support of S. 614 and S. 522. We are to submit further testimony in regard to Federal aid in the education of health workers. In general, we support such aid though the method of effectively accomplishing proper aims is not easily defined.

This association has not testified in regard to legislation which would give Federal assistance to school health programs and in research. We can assure you that legislation strengthening and expanding these important health programs would be in keeping with our over-all aims.

We wish particularly to emphasize the value of S.1456, the Voluntary Health Insurance Act. We believe that it provides a positive approach to our problem of distributing health and medical care to everyone in the Nation. It is a promise of real action and constructive action. It is not designed to destroy the existing system of providing health care. Rather it will build upon what the American people have developed through their own ingenuity and adaptability.

The voluntary health insurance bill will afford local areas a maximum of freedom to care for their own needs without the imposition of an arbitrary pattern imagined or limited by Washington bureaucrats.

Already more than 50,000,000 people have demonstrated that the quality of hospital and medical care can be maintained under voluntary health insurance. However, we have grave doubt that quality could be maintained under a system of Federal regulations. Certainly we doubt that any substantial growth would be possible under a system which can only develop by cumbersome changes of detailed regulations. This is too awkward for any problem which is as changeable as the needs of health distribution. The amazing developments in medical care within our own time have been evidence of the need for constant adaptability in provision of health services. No group is more aware of that fact than the hospital field.

Yet a compulsory health insurance program would be final. There could be no turning back. It would not be experimental. It does not depend upon free choice of the individual citizen. Rather it would be a freezing of the best that we have at the present time with little hope of continued improvement and, in fact, a destruction of many of the incentives which have developed the high quality of care which we know in this country today.

We favor the voluntary system primarily because it leads to the preservation of quality of care. We need to have that care increased. But the last thing we need in this country is an abundance of poor care.

Senator MURRAY. We will recess until 2 o'clock. We may have a few questions to ask you at that time.

Mr. HAYES. Thank you, gentlemen, for listening to this long statement.

(Whereupon, at 12 noon the hearing was recessed to reconvene at 2 p. m. this same day.)

AFTERNOON SESSION

STATEMENT OF JOHN H. HAYES, CHAIRMAN, COUNCIL ON GOVERNMENT RELATIONS, AMERICAN HOSPITAL ASSOCIATION—Resumed

Senator MURRAY. The hearing will resume. Mr. Hayes, there are some matters in your statement that I am a little confused about. You say that our bill, that is, the national health bill, does not provide assistance for those unable to pay for care. You are referring of course to those people that are on relief?

Mr. HAYES. Yes, sir.

Senator MURRAY. You say our bill does not make any provision for that?

Mr. HAYES. Nor for those that are retired, let us say, by paying so much into the scheme, those who retire, for instance, and are living on pensions.

Senator MURRAY. You say that perhaps is one of the most serious deficiencies in the bill.

Mr. HAYES. One of them; yes, sir.

Senator MURRAY. Well now, first, you must remember that the main purpose of the administration bill is to provide a system of medical care for people in the middle-income brackets. It has been said over and over again in this country that only the very well to do and the indigent are able to get medical care in this country; that the big class of people in between have great difficulty and that was one of the purposes of our bill, which provides for that great mass of people who do not want to accept charity and cannot afford to pay the high costs of modern medical care. You recognize that?

Mr. HAYES. We recognize that, Senator. That was the reason why the hospitals of the country together with the others joined with them to form the Blue Cross plan to take care of that middle-income group. That was our purpose. We realized the deficiency.

Senator MURRAY. Well, the administration plan was designed for that purpose, but we did provide in the bill for extending the same services that we are extending to the people who are within the program that are on relief—we did propose to give them the same service and supply them with membership cards, provided it is paid for by local communities or relief agencies that are responsible to them. We have a provision of that kind in our bill. So that we did take care of that segment of the population.

Mr. HAYES. I think quite generally here in America we have taken care of those people.

Senator MURRAY. Yes; I am not criticizing that, but you said that one of the most glaring deficiencies in our bill was the fact that we made no provision for them.

Mr. HAYES. On an insurance principle you do not.

Senator MURRAY. I know. They haven't got any money to pay insurance and that is the reason we put them in a separate class. They cannot pay. There is no pay-roll deduction, they are not employed and they are just unable to contribute anything.

Mr. Hayes. Well, the Hill bill does the same thing.

Senator Murray. I am not talking about the Hill bill. You are attacking my bill—our bill.

Mr. Hayes. I don't believe it is as definitely stated as it is in the Hill bill—these tickets and so on.

Senator Murray. It doesn't make any difference whether it is definitely stated. It is stated in there as clear as language could make it clear that that was the intention of the bill, that those people that are unable to pay anything, that are indigent, that the local communities cannot provide for, would get care under this bill.

Mr. Hayes. Senator, I would not for a moment doubt that your intention and that of your colleagues was to take care of everybody.

Senator Murray. Well, of course, intentions are not everything. They say the place down deep below is paved with good intentions. I am not claiming it is merely our intention. I am claiming we have an actual provision in here for that purpose. You said we didn't have anything and that was a glaring deficiency. I think you are mistaken on that.

Senator Donnell. Senator, have you pointed out what particular provision it is that you say covers that?

Mr. Hayes. I was going to ask that.

Senator Murray. Section 705, page 111. Now, besides that, we have a separate administration bill pending in Congress which undertakes to provide Federal funds for those local relief agencies to help them to pay for health insurance, organizations having local relief recipients.

Mr. Hayes. I believe that would be necessary with this to clarify it and make it effective in my reading of it. I would say so.

Senator Murray. Well, there is pending such a bill, an administration bill, H. R. 2892. I think you testified in support of that bill, didn't you?

Mr. Hayes. I appeared, if that is the one for the relief of the needy. That was Congressman Doughton's bill. I appeared in favor of that bill; yes, sir.

Senator Murray. That would enable the local relief agencies to provide the medical care that we offer the American people under our bill.

Mr. Hayes. Yes, sir.

Senator Murray. So that bill is not so bad as you thought at first.

Mr. Hayes. The other one, too, it is not.

Senator Murray. No; because you appeared in support of that bill.

Mr. Hayes. But you never know whether both House and Senate bill are going to pass, or either one.

Senator Murray. No, but we haven't passed any bill yet.

Mr. Hayes. No, that is right, and I have been coming down here for a number of years.

Senator Murray. Of course, this case where they speak about good intentions may be all right. We intend to pass this national health bill, also this one giving relief for the indigent.

Another item of our bill is section 782 on page 161, providing for Federal grants to States for old-age assistance, aid to dependent, and aid to the blind which use their funds to pay health insurance premiums for such people. Our bill has that written in there too.

As I say, we were concerned in preparing this legislation with the acknowledged situation in the country that the indigent were able to get good care and the well-to-do were able to get good care and those in between were not. That was the reason why we made the major purpose of our bill a system that would enable them to get that care.

Mr. HAYES. I believe we have all recognized that for a number of years.

Senator MURRAY. Of course, I didn't get your statement until this morning. I haven't had the opportunity to go over it carefully with a view of trying to find out exactly the position you take with reference to many of these matters. I would like to know how you propose to avoid one problem that might arise under the Hill bill, S. 1456. What would you do about the competing voluntary plans in the same area where there is half a dozen different voluntary plans? How do you propose that the Government would be able to help them carry out their plans?

Mr. HAYES. The Government does not contribute to the plan, Senator, anything except their expense of turning over the money. I assume that in any plan in that area it would be up to the State or locality to determine.

Senator MURRAY. Well, would you contribute funds and aid in the administration of their programs to each of the competing plans?

Mr. HAYES. No, not the administration of their programs; the costs involved in their securing from the Government for payment to the hospital of the amounts involved. That is all I understand it does. The Hill bill proposes that the needy person can come in and get care and the hospital will submit its bill to the local plan who issued that ticket. Through the welfare agency that local plan will get back from the Government what it pays over to the hospital plus what its administration expenses are only in connection with that transaction. That will be a mutual agreement on the part of the local plan and the local Government agency. Though I don't see any harm—there aren't any competing Blue Cross plans in the country. I doubt there is one. They all fix their areas and take care of their people in those areas. They do not cross each others' territories.

Senator MURRAY. Well, certainly there are four or five competing systems in a community. You propose that anybody that is insured under any one of those programs would get medical care through your hospital and that particular system would pay for it.

Mr. HAYES. Well, they are subscribers, but the welfare agency would first pick out which nonprofit agency it would use in order to take care of the needy.

Senator MURRAY. Well, then the local welfare agency would have to choose among the many conflicting groups of that kind.

Mr. HAYES. Well, are there any nonprofit? There are some lodge arrangements, perhaps in some areas or granges that might have some health plan. That is true, but in general I don't think you will find much in the way of competition. I don't believe they are going to allow to come into this, the commercial companies, the profit companies.

Senator MURRAY. There are a number of cooperative ones.

Mr. HAYES. Yes; the grange and so on. It is up to the local community to determine which of those agencies it believes can best perform those duties under this bill.

Senator MURRAY. Well, then, if that were true, people wouldn't have any free choice. They would have to take what they got.

Mr. HAYES. In what way wouldn't they have any free choice?

Senator MURRAY. Well, you just said it would be determined——

Mr. HAYES. Well, if he is a member of a grange group, of course, he would be one of the farmers, but I say the Blue Cross plans do not compete with each other. They cover their special territory throughout this country in every State.

Senator MURRAY. Well, with reference to the people in the low-income groups that want to get voluntary insurance, you propose that you would aid any person who was unable to pay the full payment required in a voluntary plan?

Mr. HAYES. That is right.

Senator MURRAY. You would not discriminate between different plans? If there were a half dozen different plans, you would render the same assistance to the people in the different plans?

Mr. HAYES. The likelihood of a half dozen nonprofit plans in any area seems extremely remote to me.

Senator MURRAY. There are some places——

Mr. HAYES. Some cooperatives—if the people of that cooperative or the people of that area wanted that agency to be the local distributing agency for those cards that could be done at the local level.

Senator MURRAY. Well, how about San Francisco. There are a number of competing plans out there; aren't there?

Mr. HAYES. There is only one Blue Cross.

Senator HAYES. They have in San Francisco a Blue Cross hospital plan which sells some medical care. They have a Blue Field medical plan. They have the Henry Kaiser permanent plan which sells a more comprehensible insurance.

Mr. HAYES. That is an individual industrial plan. The corporation runs its plan for its own employees.

Senator MURRAY. There are several nonprofit organizations for French people and Italian people, each of which provides some health insurance.

Mr. HAYES. That is right. I think the local welfare officials would be well able to determine that.

Senator MURRAY. They woudn't have any right to determine that. If I wanted to join a French cooperative plan, I don't see how they could compel me to join the Italian plan.

Mr. HAYES. If you joined the French plan, you would be paying dues.

Senator MURRAY. Well, suppose you wouldn't be. Suppose you couldn't pay dues.

Mr. HAYES. Then you would be out of that plan.

Senator MURRAY. That is just the point.

Mr. HAYES. The hospital service in any event would be exactly the same.

Senator MURRAY. Under your program you are going to assist those people who cannot pay the full charges?

Mr. HAYES. That is right.

Senator MURRAY. So that, if I join the French system, why would you assist me to pay my dues in that system?

Mr. HAYES. The welfare commissioner would give the tickets, sir, to go to a hospital. Whether he would pay for that to the hospital through the French plan or the Blue Cross is of no concern to the hospital. We wouldn't worry about that.

Senator MURRAY. I am talking about your law. You are advocating 1456, which would undertake to furnish assistance to these voluntary plans.

Mr. HAYES. The plan wouldn't be rendering that assistance, Senator. It would be the welfare organization of that locality that would be doing it, would be paying for it through a nonprofit group.

Senator MURRAY. Well, I am talking about where there are two or three voluntary plans in existence.

Mr. HAYES. Yes, sir.

Senator MURRAY. And some member of one of the plans is unable to meet the full charges, the full fees that he has to pay, and under your program the welfare organization would have to furnish him with the money to keep his card in good standing.

Mr. HAYES. That is right.

Senator MURRAY. And they would do the same thing for every voluntary plan of that same kind.

Mr. HAYES. That is right. Yes, sir.

Senator MURRAY. It then furnishes any money to help to pay these administration expenses of the various plans.

Mr. HAYES. That is in there that they should pay the cost of the hospital and medical care plus the administrative costs of the plan. It is all on a nonprofit basis. That has been done by the Veterans' Administration, you know, in various parts of the country, that same system, where veterans with service-connected disabilities have been placed in voluntary hospitals, and the Blue Cross, for instance, in New York, would pay my hospital bill and collect from the Veterans' Administration plus their administrative costs in carrying through that transaction.

Senator MURRAY. Well, now, I notice that in your statement you said something to the effect that these people in low-income groups that are unable to pay part of their premium would be provided for. Well, now, of course, there is nothing wrong about that, but you go ahead and say there is nothing to worry about even though they do not keep their cards in good standing, because they can come in and get care anyway for their own serious illness; is that true?

Mr. HAYES. If they are needy; yes.

Senator MURRAY. Then there would be no encouragement for people to try to keep up their memberships in a voluntary system, naturally.

Mr. HAYES. Yes; there would, because they would still have to show their need to the welfare commission, not to the hospital. They would still have to prove their need. These cards are distributed by the welfare department.

Senator MURRAY. But it would put all those people who were trying to be independent and not to accept charity, who might be unable to pay part of their cost of keeping up their system, it would allow them to drop their cards entirely and rely upon the provision of your bill which says they shall get a card just the same, whether they are in good standing or not.

Mr. Hayes. If they can show the need, but as a general rule these payments in the Blue Cross are deductions from the pay roll on the part of the employer and they are not dropped. The member continues and those that get in as a general rule stay in, I think, almost unanimously, and continue it after they leave their employer's place. There can be abuses in any system, but I think there would be very little in that, if any.

Senator Murray. Well, it seems to me there would be no encouragement for people to try to go as far as they could in maintaining their standing in a voluntary plan if it was known that the Government was going to take care of them anyway.

Mr. Hayes. Well, I like to think that the vast majority of our people do not feel that way.

Senator Murray. Well, that is what 1456 undertakes to provide. It says on page 7, paragraph 10:

> *Provided,* That the determination of eligibility shall be made insofar as possible in advance of need for hospital and medical care; that the individuals shall not be identified as persons accepting assistance at the time of receiving the card; that the individual shall not be provided a separate card or classification of care because of his accepting assistance.

Mr. Hayes. Yes, sir. I don't even know Senator Hill, but I believe that is the answer to the many complaints that have been made in these hearings as to the means test of determining need. That is the elimination of that basis on the part of the proponents of the compulsory plan.

Senator Murray. But the fact remains that under this that they would undertake to determine eligibility in advance so far as possible, but it would seem to me that under that kind of a program there would be no encouragement or no incentive to require people to keep up their payments in a voluntary system because they are going to be taken care of regardless.

Mr. Hayes. I cannot feel that way any more than I would about their life or fire insurance. They once have it; they feel it is a good thing and continue it, the same way as we continue accident insurance. Many of us fortunately never have an accident, but we keep paying every year.

Senator Murray. Well, I had health and accident insurance and I carried it for about 40 years. I never collected a nickel out of it. They discontinued it on me since I got to be 65.

Mr. Hayes. I am not so far away from that. I hope they don't discontinue mine. I have been fortunate so far.

Senator Murray. Well, I haven't had time as I say to go over your statement completely, Mr. Hayes, but it might be I might desire to submit a few questions to you after studying it over a little more carefully.

Mr. Hayes. I would be very happy to answer them.

Senator Murray. Senator Donnell.

Senator Donnell. I would like to ask Mr. Hayes a few questions. Mr. Hayes, I didn't hear your testimony this morning. I might in these few questions duplicate something you have already said, but I would like to ask the questions at any rate. On page 26, I notice, in your prepared statement, you say that already more than 50,000,000 people have demonstrated that the quality of hospital and medical care can be maintained under voluntary health insurance. However, continuing, you said, "We have great doubt that quality could be maintained under a system of Federal regulations." Would you be kind enough, Mr. Hayes, to tell us why you have grave doubt that the quality of hospital and medical care which can be maintained under voluntary health insurance could not be maintained under a system of Federal regulations?

Mr. HAYES. Well, I believe that in medicine and hospital care we have made our advances under the American competitive system, and I feel that under a compulsory-care plan we would have—we would undoubtedly come down to a general pattern fitted to the amount the Government would pay and a great deal of our incentive would disappear. That sounds like a very unusual statement for anyone who is connected with medical care, but I have read a great deal about what has happened in other countries where compulsory insurance has gone in and where medical and hospital care has come down to a pattern, and that pattern does not compare with the kind of care which we are giving to our people in this country. I think that philanthropy and the desire to be our brother's keeper and all of those things have done a great deal to improve medical and hospital care of the people of this country.

I think that they will continue to do that if we are allowed to continue the way we have.

I might mention right now, Senator, I have had my friends ask me, a few of them, why do I combat compulsory insurance when I am fighting deficits for over 23 years in my hospital and here apparently is a scheme whereby I am going to get all the money I need. I am going to get my costs and so forth.

I wish you gentlemen will understand we have no mercenary motive. If we had, we would certainly favor compulsory insurance.

Senator DONNELL. Is this nonprofit?

Mr. HAYES. Yes, sir; and our basis of doing this is that we think he can give better care to the people under the system that is now employed with its many faults, with the faults of Blue Cross. Nothing is perfect. We believe that the improvement that has been shown, the lengthening of the span of life and all of the many things that have come through American medicine and hospital care will continue.

Senator MURRAY. You don't claim all came through American medicine and hospital care?

Mr. HAYES. These improvements?

Senator MURRAY. The advances in life.

Mr. HAYES. Oh, no. I still maintain, Senator, in that direction you gentlemen here who have just come back from the shadow of the Capitol found slums that should not exist. I think a great deal can be done for the health of the people in housing, nutrition, shelter of all kinds, clothing——

Senator MURRAY. But you just made the statement, though, that these great advances in this country came from medical care or hospitalization.

Mr. HAYES. No; I made the statement that the advances have been made under the system which is now in effect, the advances in medical care and hospital care have been made under this system. That is what I intended to say.

Senator DONNELL. Mr. Hayes, it seems to me your point is perfectly clear and well stated, as I understand it. May I just paraphrase it a little and see if I do understaand your point exactly. I asked you in substance why it is that you have grave doubt that the existing quality could be maintained under a system of Federal regulations. Now let me just ask you these few questions.

In the first place, today if a hospital is operating out in Denver and makes some improvement it takes a certain pride in trying to advance itself and tries to make itself of the utmost utility which rather spurs on other hospitals over the country to do likewise, does it not?

Mr. HAYES. Not only that, but we all get busy right away. There is competition about it.

Senator DONNELL. In other words, even in hospitals there is something analogous to competition?

Mr. HAYES. That is right.

Senator DONNELL. In other words, the hospital is trying to utilize the best services, it is trying to utilize the best practices in that hospital.

Mr. HAYES. That is right, to add to its service and prestige.

Senator DONNELL. You are familiar with the fact, of course, that in this bill, S. 1679, that this Board, this National Health Insurance Board—if you will turn to the bottom of page 137 and top of page 138, it says that the Board shall make all regulations and standards specifically authorized to be made in this title and such other regulations not inconsistent with this title as may be necessary.

So that you have there a national board making regulations applicable to the entire country. I presume they could make them as to localities if they wanted to but certainly it would be a national board making a series of regulations emanating from the national headquarters, and those headquarters, by the way, or the Board at least may delegate its functions to the Federal Security Administrator, is that right?

Mr. HAYES. That is right.

Senator DONNELL. As I understand your point—if I am wrong please correct me, that today where you have hundreds and perhaps thousands of hospitals, I don't know how many there are over the country—you would know.

Mr. HAYES. Over 6,000.

Senator DONNELL. Over 6,000 hospitals, ranging from the little hospitals in a town like Carrollton, Mo., or going up a little higher in my own State, St. Joseph's Hospital up in Maryville, Mo., not a large establishment, on up through other hospitals they are all in a sense competing in ingenuity and skill with all the others. They are not subject to a regulation or series of regulations emanating from one board under the supervision of one man. Am I correct in that or am I not?

Mr. HAYES. That is true.

Senator DONNELL. Your idea is, as I understand it, that a system which on the contrary provides for a system of regulations made by a national board under the supervision and direction of one man is not as likely to produce this freshness and continuity of enterprise and competitive ingenuity as the present system. Am I correct in my understanding of your statement?

Mr. HAYES. Yes.

Senator MURRAY. Right there, Senator, I would like to call your attention to S. 1456.

Senator DONNELL. That is the Hill bill?

Senator MURRAY. Yes. It has a provision almost identical with the provisions you are now criticizing, in section 723 of S. 1456, on page 16, beginning with line 20. It provides, and I quote:

> The Surgeon General is authorized to make such administrative regulations and to provide such other functions as he finds necessary to carry out the provisions of this Act. Any such regulation shall be subject to the approval of the Administrator.

Senator DONNELL. Well, I may say that I am not here presenting S. 1456.

Senator MURRAY. But the witness is presenting it.

Senator DONNELL. That is all right. He can present whatever bill he favors, but the point I am making is——

Mr. HAYES. We are in favor of provisions in both of those bills and I am stating in here to that effect.

Senator DONNELL. I haven't studied Senator Hill's bill. He made a statement here the other day but I am not here advocating that bill. I was trying to develop this thought which it seems to me is most excellent and most interesting and most important, namely, that if you have regulations—it may be true of both the Hill bill and the administration bill, I don't know about that but I know it is in the administration bill, what I have said here, and your point is that the ingenuity and the competitive enterprise that today prevail will not—that is to say, they are much more apt to produce skill and constantly advancing efficiency of technique than if a system such as is in S. 1769, is that correct?

Mr. HAYES. That is correct. Of course, section 723 goes on with this Federal Hospital and Medical Care Council, and that goes down into the States, then down into the locality—these councils in the Hill bill.

Senator DONNELL. Now I wanted to mention also in the administration bill—do you have the administration bill right there too?

Mr. HAYES. Yes, sir.

Senator DONNELL. At page 119, down at the bottom of that page it provides the board—that is, this National Health Insurance Board—which again to state it as I have before, is a board, the functions of which shall be administered, according to pages 137 and 138, under the direction and supervision of the Federal Security Administrator.

That board, after consultation with the Advisory Council and with representatives of interested hospital organizations, may by regulation prescribe maximum rates for hospitalization furnished as benefits under this title and such maximum rates may be varied according to classes of localities or types of service. So that under the administration bill, the board, which is described in here as under the supervision and direction of the Federal Security Administrator, does have the power after this consultation to prescribe the maximum rates for hospitalization; is that correct?

Mr. HAYES. Yes, sir; and that is what we fear as setting the pattern and as limiting what we are trying to do.

Senator DONNELL. Yes. Now Mr. Hayes, you refer, as I have hastily glanced through part of your written statement, you have referred to the experience in the Province of British Columbia after the enactment of a compulsory hospital insurance law, and you refer particularly to the experience of the Blue Cross plan in that province after the compulsory hospital insurance law was enacted. I read here that the Blue Cross plan in that province went out of business.

Mr. HAYES. That is right.

Senator DONNELL. Why did it go out of business?

Mr. HAYES. Because the people were not going to pay more that way when they had to pay taxes to support it the other way through the Government. May I bring in something that is perhaps not too closely related at this point? I am greatly puzzled these days by the fact that I know the veterans in this country are opposed to compulsory insurance. The American Legion in its last three conventions has uttered resolutions stating that fact. There are 18,000,000 veterans and I assume that the vast majority of them are workingmen and a great majority are in the labor unions of this country. I also know that the miners have their own welfare scheme which they are very happy with; that the garment workers have theirs, among others; some industrial ones have been in use for years such as the Kaiser plan, but I am puzzled for this reason that in my opinion the average workingman in this country has two voices. One says that he does not want compulsory insurance and the other says he does. I am puzzled as to how you gentlemen know what the country wants.

Senator MURRAY. You say he has two voices?

Mr. HAYES. The average workingman, one, through his trade union, the other through the Legion. I am talking about the 18,000,000 veterans in this country who say they don't want to pay insurance for something they are entitled to anyway as veterans. They are determined they don't want it, but the unions to which so many of them belong, they came out yesterday and today, stating that they are in favor of compulsory insurance and it is the only cure for this. I just don't understand who is qualified to talk for these millions of men who are the workingmen and who would be paying these taxes, one and a half percent or more.

Senator DONNELL. One spokesman is saying "Yes," they want compulsory health insurance and the other is saying "No," and they are representing the same constituents largely.

Mr. HAYES. Yes.

Senator DONNELL. You are wondering——

Mr. HAYES. I am wondering how you gentlemen know. You naturally want to do what most of the country wants to do.

Senator DONNELL. Now referring again to British Columbia, how soon after the enactment of the compulsory hospital insurance law was it that the Blue Cross plan in the province went out of business?

Mr. HAYES. I am not sure, Senator, but I think it was weeks.

Senator DONNELL. On page 9 of your statement you say this:

> It is thought—

I assume you mean you think—

> it is thought that the enactment of such a system in this country would either force the Blue Cross plans out of business or limit them to carrying special types of risks.

Mr. HAYES. That is right.

Senator DONNELL. I am not clear as to just what types of risk they might be still carrying on. What do you mean then?

Mr. HAYES. They would perhaps have to take these people that are on pensions or other groups that won't have the pay-roll deductions and which will be, of course, a smaller number, and would have to take them on at perhaps higher rates because a great many of those are older people.

Senator DONNELL. Would you say that by far the great majority of the persons in Blue Cross plans would disassociate themselves from the Blue Cross because these services would be taken care of by the taxation, either pay roll or a general tax of the Government?

Mr. HAYES. It is only natural to assume it because the vast majority of the Blue Cross subscribers are under the pay-roll deduction plan now.

Senator DONNELL. Now, Mr. Hayes, you referred to other countries, the experience in other countries. Have you personally studied within the last year just what is going on in other countries along the line of compulsory health insurance?

Mr. HAYES. I have read both sides. In New Zealand, their great problem down there—I have read naturally both sides—and through a couple of friends in England I have had letters. I have read the good and the bad, and as Senator Murray said this morning, we can take our choice. Some say it is fine; some say it is not. I believe the average man in the street thinks it is fine because he is getting something that he thinks he is getting for nothing, which, of course, too many of us think too, that when the Government pays for it we are not paying for it.

Senator MURRAY. Don't you think a man working down in a mine, taking his life in his hands every time he goes down the shaft, is paying for medical care when he contributes to the success of our economic system?

Mr. HAYES. Certainly.

Senator MURRAY. And isn't he entitled because of his participation in our society to have food and clothes and medical care?

Mr. HAYES. Absolutely, Senator.

Senator MURRAY. Well, you say he is expecting to get something for nothing. How do you figure a man is getting something for nothing when he is getting what he gets in that fashion?

Senator DONNELL. Pardon me. I think Mr. Hayes said it directly the opposite. He said he thinks he is getting something for nothing, and Mr. Hayes' thought was that nobody gets anything for nothing.

Mr. HAYES. That is right. I am very much in favor, although a great many of my friends disagree with me, I think the miners' welfare fund is doing a great job. I have every reason to feel, with the cases we have—we have six or eight of those people with their backs broken in my own hospital, building them up, getting them ready for rehabilitation, and the mine workers, the union, pays all of our costs, even supplying us special appliances for those people.

Senator MURRAY. You are satisfied with John L. Lewis' system?

Mr. HAYES. Well, it seems to work out all right. We don't get out in the mines and see what happens to these people, but I think they are really getting a fair deal or a good deal in this thing.

Senator MURRAY. Do they hire their own doctors?

Mr. HAYES. They pay the doctors on our staff.

Senator MURRAY. They pay them?

Mr. HAYES. They pay them.

Senator MURRAY. You don't pay them on a fee basis?

Mr. HAYES. On a fee basis depending on what specialty they are in.

Senator MURRAY. My understanding is that under his plan they hire doctors like they do under the Permanente plan.

Mr. HAYES. They may, but you see, there are certain cases like these paraplegics they send up to us. We have quite a reputation for taking care of them. As I say, we have six or eight of them.

Senator MURRAY. I am talking about their general plan.

Mr. HAYES. I don't know what they do at the mine. They may pay the men on a salary basis.

Senator DONNELL. Mr. Hayes, returning to New Zealand, will you tell us from your study what major problems have been before the people of New Zealand.

Mr. HAYES. The major problem is abuse on the part of the public.

Senator DONNELL. In what respect?

Mr. HAYES. Overuse by neurotics, hypochondriacs, and so forth; perhaps not too good cooperation on the part of the doctors, because they made out far better than the doctors in England have been making out under this scheme.

Senator DONNELL. What has been your best information from England as to the operation of its system?

Mr. HAYES. Well, as Senator Murray said this morning, some think it is good, some think it is bad.

Senator MURRAY. It has not been in operation long enough to tell.

Mr. HAYES. I don't think it has operated long enough. I know there are a great many abuses; people go for extra pairs of glasses, and so on.

Senator MURRAY. And extra sets of false teeth.

Mr. HAYES. An extra toupee, and that sort of thing. But we haven't had that abuse in Blue Cross.

Senator MURRAY. You say in New Zealand it has been greatly abused by so many neurotics?

Mr. HAYES. Well, that is part of it, constantly going to the doctor and no great attempt on the part of the doctor to keep down the visits.

Senator MURRAY. Do you think that situation would develop in this country? Would the people all be flocking to the hospital if we passed the national health bill?

Mr. HAYES. I wouldn't positively say they would all be, but I would say a great many would.

Senator MURRAY. Oh, yes; a great many would.

Mr. HAYES. Yes.

Senator MURRAY. You think they would go to the hospital in order to get medical care whether they needed it or not?

Mr. HAYES. That is right. I think that is human on the part of some people that they would do that. I am quite sure they would. Of course, one of the things you get from the medical profession, in my opinion, is the fact that no man can give any real care or time with 4,000 people on his panel, but the average doctor needs that many in order to come out with a few dollars saved at the end of the year. Of course, in this country I think the situation we have is one doctor to 1,500 people.

Senator MURRAY. Those are matters that all adjust themselves in time, it seems to me. I don't know what the situation in England is with reference to the number of doctors or whether they have sufficient medical personnel, but it seems to me at the commencement of the program naturally people who have been unable to seek medical care before would no doubt flock in, especially people who needed dental care, for example.

Mr. HAYES. Of course, my own opinion is Britain has been taking too great a stride at one time. That is what this bill does, it seems to me. Over the last few years I have testified for the Taft bill, and we believe in these slow steps. As Senator Hill stated yesterday, the services are necessary. We have to determine what the next best step is as we go along, not this tremendous stride which will completely change the complexion of medical and hospital care all at one time with no assurance it is going to make it better. We cannot provide more medical care than we have without having more people. We in the hospital groups in the various States are always careful to see that hospitals are not going to be put up somewhere without help to run them.

Senator DONNELL. Mr. Hays, there is one place on page 11 that I don't quite understand in your testimony, and I was going to ask you if you would amplify it. You quote from section 705 (a) of S. 1679, the compulsory health insurance proposal.

Mr. HAYES. Yes, sir.

Senator DONNELL. Then you say:

> Do you notice that under this provision the Federal Government would provide no assistance whatever in financing care to these unfortunate people for whom the need is greatest? The entire burden for the indigent would be left upon the States and local communities under the compulsory health insurance program, plus the added costs of Federal administration. If the States and local communities did not pay premiums into the Federal Government, these needy individuals would receive no protection.

Now, the question that arises in my mind and in your mind arises at lines 21 and 22 of 705 (a); and that is the use of the term "by public agencies of the United States, the several States, or any of them," and so forth. Do you think it is clear that under section 705 (a) the Federal Government would provide no assistance whatever, or do you think the language I have read "public agencies in the United States," would mean the United States Government would provide some of the assistance?

Mr. HAYES. Well, it is not clearly stated that the Federal Government—Senator Murray, I spoke about that a few minutes ago—to my mind it is not clear that the Federal Government is going to do this immediately under this bill. It might as the need arose and as this act might come into effect, but to my mind it doesn't show we would do any more than we would be doing today, taking care of it locally and statewise.

Senator DONNELL. I think that is all, Mr. Hayes. Thank you very much.

Senator MURRAY. Thank you, Mr. Hayes.

Mr. Hayes. Thank you, gentlemen.

Senator Murray. Now, Mr. John H. Olsen.

STATEMENT OF JOHN H. OLSEN, PAST PRESIDENT OF THE AMERICAN PROTESTANT HOSPITAL ASSOCIATION

Senator Murray. You may state your full name and the organization you represent, your residence, and so forth.

Mr. Olsen. For the record, my name is Olsen, Senator, John H. I am past president of the American Protestant Hospital Association, which I have the honor to represent at this hearing. I am also a past president of the Hospital Council of Brooklyn, a life member of the American Hospital Association, and a member of the American College of Hospital Administrators, the Hospital Association of the State of New York, and the Greater New York Hospital Association, and also serve as a member of the advisory editorial board of Hospital Management.

I am the administrator of the Richmond Memorial Hospital, Dreyfus Foundation, Prince Bay, Staten Island, N. Y., serving my twentieth year in that capacity, and 5 years longer as a member of its board of directors.

Senator Murray. Are you active in all those organizations?

Mr. Olsen. Yes, sir. For over 30 years. My health has been good, and I haven't missed a meeting of the American Protestant Hospital Association in 29 years.

The members of the American Protestant Hospital Association are greatly interested in matters now before you and the serious manner in which they may concern our sick.

Rev. Chester C. Marshall, D. D., president of the American Protestant Hospital Association, has said:

> There is no doubt in my mind that our association would vote unanimously its disapproval of bill S. 1679, introduced by Senator Thomas and others, providing for compulsory health insurance; nor do I have any doubt that strong approval would be forthcoming for either the Hill bill or the Taft bill, S. 1581.

Dr. Marshall further states:

> As president of the American Protestant Hospital Association I signed a statement a few weeks ago endorsing the main provisions of a bill then in the course of preparation and which subsequently was introduced in the Senate by Senators Hill, O'Conor, Withers, Aiken, and Morse—

Senators Lister D. Hill, of Alabama; Herbert R. O'Conor, of Maryland; Garrett L. Withers, of Kentucky; George D. Aiken, of Vermont; and Wayne Morse, of Oregon.

> The provisions of this bill seem to be completely consistent with the official position of the American Protestant Hospital Association as stated in the resolution adopted on September 18, 1948, at its twenty-seventh annual convention at Atlantic City, N. J.

Report of Resolutions Committee at the American Protestant Hospital Association Twenty-seventh Annual Convention

> The resolutions committee views with alarm the reported activities re compulsory health insurance, health aid, control of medical care of our people, and the discussion over the extent of Federal control of State and local health organizations versus noncontrol, and the committee expressed the hope that matters relating to health and facilities to provide the necessary care for the sick may

be approached from high humanitarian broad economic levels and not from a partisan political one.

The committee hopes that this vital matter of the health of our people may not become a political football to be bandied about by political parties. The committee welcomes the discussion by the press and the reports of the pros and cons by different individuals, groups, organizations, and governmental agencies of proposed governmental health programs.

Without prejudice to plans which have been under discussion during the past years, the committee is of the opinion that no plan or policy should be adopted until the plan has been explored and approved by the joint committee of the American Hospital Association, the Catholic Hospital Association, and the American Protestant Hospital Association in conjunction with the American Medical Association, health agencies, Government agencies, the combined findings of these organizations to be presented and made available to committees of the House of Representatives, the Congress, the President of the United States, and governmental departments.

Whereas the good health of the men, women, and children of our several communities is the goal of our health agencies, including hospitals; and

Whereas studies and surveys of recent date have indicated the necessity for concerted action in providing increased facilities, personnel, and finances in order to cope with the problems which confront hospitals; and

Whereas in this democracy burdens are spread among the many, and the strong support the weak; and

Whereas great institutions of merciful help for the afflicted have multiplied in the land by reason of philanthropically minded men and women; and

Whereas our democratic customs emphasize freedom with liberality: It is therefore

Resolved, That the American Protestant Hospital Association record its approval of its officers and representatives in their efforts to effect and improve the systems of voluntary prepayment plans for the care of hospital patients and urges them to cooperate with other associations for the care of the sick wherein the people of our communities may freely choose the agencies for their care and the organized vehicles for periodic payments such as represented by Blue Cross plans for financing their care.

The president of the American Hospital Association, Joseph G. Norby, speaking at Peoria, Ill., December 8, 1948, said:

> The aim of the announced Government policy regarding the health of the Nation's citizens and that of the American Hospital Association are the same * * * but compulsory health insurance is not the way.

In addition to being unnecessary, Mr. Norby continued:

> Compulsory health insurance would destroy the quality of medical service in the United States.

Mr. Chairman, I have a copy here of Mr. Kenneth C. Crain's brief on compulsory health insurance under Federal legislation, appearing in Hospital Management, January 1949. With your permission, sir, I would like to make that part of the record.

Senator MURRAY. It may be made a part of the record.

(The brief above referred to follows:)

TO THE CONGRESS OF THE UNITED STATES—A BRIEF ON COMPULSORY HEALTH INSURANCE UNDER FEDERAL LEGISLATION

(By Kenneth C. Crain. Reprinted from Hospital Management, January 1949)

It is proposed to examine in this discussion, in such detail as may be necessary the following points:

1. The reasons advanced in support of the proposal for a compulsory health-insurance system, and their fallacy, including the matter of rejections for selective service.
2. The fashion in which the present system of individual health care operates as to both medical and hospital services, the care of those who cannot pay for such services, and the methods of arranging prepayment.

3. The record of government-controlled health care in this country and in others, including Germany, Great Britain, and New Zealand.

4. The cost of a compulsory health-insurance system under social security and the difficulties already confronting social security and the taxpayer without this added burden.

The above outline indicates that this is an attempt to place before the Congress, fully but as briefly as possible, all of the considerations involved in the proposal to adopt by Federal legislation a compulsory system of health insurance. The reasons advanced in support of these proposals will be examined, as well as the arguments against them. The subject not only deserves, but demands, the most serious attention of this Congress, because the Federal plan transcends partisan political considerations and approaches the revolutionary in its theory and its probable effect upon American life.

It should be emphasized at the outset, especially in the light of the necessity for the most careful examination of the whole matter strictly on its merits, that it was in no accurate sense subjected to a referendum of the people in the recent election. While health insurance was mentioned in the Democratic national platform and in the campaign, the 21-point legislative program submitted to Congress by the President in his message of September 6, 1945, which on November 16, 1948, he indicated still to contain what he termed the "main bearings" of the course of his new administration, conspicuously omits the subject. It might reasonably be inferred that some of the serious difficulties involved, financial, administrative, and ethical, led to this omission.

It is pertinent in this connection, moreover, without any attempt at detailed and controversial analysis, to refer to the fact that, out of a total of around 95,000,000 possible voters, only 48,690,075 actually did vote, and that of this total about 24,100,000, or less than one-fourth of the possible grand total, voted for the winning national ticket. Under the American constitutional system, this decided the result; but it conferred no mandate for any purpose, and it would be the gravest injustice to the country to press for passage a compulsory health-insurance plan on the plea, so obviously ill-founded, that the people demand it.

Let us therefore examine the concept of a Federal compulsory system of health-care insurance to see whether it should for sound reasons be enacted into law or whether it should for sound reasons be rejected. This is the responsibility of the Congress to the whole people, as well as to the professional groups who have as their personal and professional responsibility the care of the people's health.

THE ARGUMENTS FOR A FEDERAL PLAN

The reasons advanced in support of the idea of taking all individual health care under permanent Federal control have become so well known that it is necessary to refer to them only briefly. They rest upon the general assertion that the American system of care, with the free practice of medicine, dentistry, and nursing, and various types of hospital care, including especially the voluntary nonprofit community hospitals used by most people, while good in many respects, has become inadequate. They refer particularly to the fact that many people are unable because of limited resources to pay the costs of their health care, and therefore propose a compulsory insurance system to be paid for by Federal taxes levied upon all who work and their employers. They compliment the present extensive and rapidly expanding nonprofit and commercial prepayment plans, but again condemn them as inadequate. They appear to agree that the utmost possible degree of freedom, except the freedom not to be taxed for it, should under a Federal system be left to the individual citizen as well as to those who must render the required services, and promise that no real deprivation of liberty will result, whereas on the other hand they confidently assume a great improvement in individual health care.

An enormous mass of conflicting evidence, of statements pro and con, has been accumulated in the course of the attempts of Congress for several years to examine this subject in connection with the several bills which have been introduced relating to it; and undoubtedly many conscientious Members of both Houses have mined this mass for information. Eight volumes of reports of the hearings on the general subject of the so-called national health program before committees of the Seventy-ninth and Eightieth Congresses alone offer nearly 5,000 pages of material to the investigator, and search will produce valuable results. Some reference will be made later to specific material in these volumes.

The total is mentioned only to show how extensive and earnest the investigation has been. It is also true that a large part of the material consists of material from Government employees in the offices which would be greatly expanded in authority and power by the enactment of such a law, and there are also extensive contributions by some of the legislators strongly in favor of it. Numerous organizations with no actual knowledge of the subject have recorded their views, as well as representatives of organized labor and of the medical, hospital, and other professional and technical groups interested.

The scope of the proposal is virtually unlimited, in view of the present plan, which will have to be examined and converted into legislation in advance of the health-insurance idea, to extend the coverage of the social-security system to all who work, including the self-employed such as farmers, professional, and small-business men, and members of the armed forces. Directly connected with this extension of social security is the conceded necessity for increasing the present painfully inadequate benefits under the old-age and survivors' insurance set-up which at present comprises a major part of the social-security system. The costs which this will involve are very large, and this and other aspects of the extension plan will be considered later in some detail. The scope of the health-insurance plan, in this light, would add to the social-security problem the individual health needs of the entire present population of about 147,000,000 persons, and the plan must be thought of in that light.

THE PRESENT SYSTEM OF INDIVIDUAL HEALTH CARE

How do Americans, for the most part self-supporting and self-respecting, see to their own and their families' health as things now are? Well, they must in the first place always use some judgment as to what to do, notably as to whether to visit or to call in the doctor, with such factors involved, stressed by the advocates of Federal care, as the nature of the illness, the accessibility of facilities, and the cost. Under a national health-insurance scheme the matter of cost would not be a deterrent, since the bill would go to the Government, with certain results which will be examined later. Accessible facilities would not automatically follow Government insurance and control, either, though this has been lightly assumed.

While it is true in some cases necessary care is at present not sought because of the cost, it is certainly also true that virtually everywhere a serious need is attended to by doctors and hospitals, regardless of the patient's ability to pay. This fact is not challenged. A survey conducted by Hospital Management in 1943 revealed no instance where a hospital would refuse to care for a person needing care, regardless of his lack of money. The free work done by most doctors as a part of their professional duty to the community is extensive but unadvertised, and is accepted as a matter of course.

Medical Care

The medical needs of the country are served by the largest and best-trained corps of physicians and surgeons in the world of whom the great majority, about 140,000, are members of the American Medical Association, which is strongly opposed to working under a Federal compulsory health-insurance system. Other practitioners of the healing art, including dentists, may produce a grand total of 250,000, while registered nurses number about 435,000. These men and women are scattered all over the country, roughly in proportion to the population.

Some of them work for hospitals or other institutions, governmental or otherwise; but the majority of the physicians and dentists are engaged in private practice under what is known as the fee-for-service system. That is, they treat the patient according to his needs, and charge him as a rule according to his ability to pay; which means that in some cases he pays little or nothing, while in others he pays too much. The latter kind of case has impressed the average cautious citizen with the desirability of negotiating in advance in case of the danger of an excessive bill.

In general, it may be asserted that the system works. In defense of it, it may be stated with emphasis that it is a great deal better, both in the availability and in the quality of the services rendered than any other system in the world, and that it shines with special brilliance by comparison with the systems of care operated by Government, here or anywhere else. One important point is that, contrary to the assertions which have been made by the advocates of Federal care, the number of physicians is increasing steadily, and at a more rapid rate than the general population. According to reliable authorities, 10 years ago there was 1 doctor to every 800 persons in the country. There is now 1 to every 760 persons, and by 1960 there will be 1 for every 700 persons. More physicians are being trained than ever before in the country's history. This situation is worth comparing with the recent British permission for a doctor to handle a maximum of 4,000 patients, under the National Health Service.

The Blue Shield plan

Medical men themselves have recognized the desirability of making it possible for the self-supporting citizen to provide for his medical care by some form of insurance prepayment, as bills have grown larger with the advance in medical knowledge and scope of treatment, and major surgery, with its unavoidably high costs, has become fairly common. The Blue Shield nonprofit prepayment plan was therefore inaugurated a few years ago, with the active sponsorship and cooperation of the doctors, and like Blue Cross, has grown so rapidly that it already has over 10,000,000 members.

Operating in effective liaison with the Blue Cross hospital-care plans, and in many cases administered and sold by the same organization, it promises eventually to make available to the whole country, at moderate cost, the opportunity to secure protection against the cost of medical care, as well as assurance by the doctors themselves, as sponsors of the plan, of the availability of such care. Of course, only the compulsion of a Federal statute can force people to buy medical and hospital-care insurance, and the widespread objection to such compulsion, enforced by an income tax in addition to all other taxes, is entirely sound.

This objection is characterized by the advocates of the Federal plan as "emotional," which it may very well be, since the American people have a strong emotional feeling about their personal liberty; but it happens to be based on the principle of individual responsibility, which is the very root of the American national character, and which will be lost or destroyed at grave risk to the country's future.

The doctors and dentists themselves are, of course, among the most vigorous opponents of Federal compulsion, to be exerted not only on them and their fellow workers in individual health care, but upon virtually the entire population. Their objections are based upon a variety of sound reasons, some of which will be dealt with in detail elsewhere.

The professional man is above all an individualist, or he would not enter work which calls for 10 years of intensive study following his secondary schooling, and for sufficient initiative thereafter to enable him, in the typical case, to select his location in some American community, settle down in it, and eventually to earn a living as an independent doctor or dentist. His objection, therefore, to being placed permanently under the intensive regulatory control of a Government bureau as to his practice, including who may and may not be his patients, his fees, records, reports, method of billing, and so forth, is easy to understand. He can point, moreover, to the fact that such a system has recorded unvarying failure in other countries.

He recognizes the desirability of aiding the public, including his own patients, to pay for his servies, and for that purpose he has cooperated in the establishment of the Blue Shield plan. He does not want this plan controlled in any respect by others than doctors, and this, too, can be understood. He and his fellows are making this plan workable and generally accessible to the public, at reasonable cost. That is all that may properly be asked of him.

Has this system of medical care been the costly failure which is alleged by those who declare that only Federal compulsion can produce good health? On the contrary, American health is actually the best in the world. A current bit of convincing evidence is the recent report by a leading life-insurance medical authority, Dr. Louis I. Dublin of the Metropolitan Life Insurance Co., indicating that the American people were never healthier than in 1948, and that prospects for the coming year are for continued improvement. The 1948 death rate established a new all-time low, with a figure slightly below 10 per 1,000 population, according to Dr. Dublin, despite such changes in the population structure as a large increase in the number of infants, on the one hand, and the proportion of old people, on the other, both tending to increase the death rate. Mortality rates in 1948 fell at every age level.

The increase in hospital service from 1931 to 1947

Totals	General hospital		All hospitals	
	Beds	Patients admitted	Beds	Patients admitted
1947	592, 453	14, 665, 195	1, 425, 222	15, 829. 514
1946	641, 331	14, 051, 508	1, 468, 714	15, 153, 452
1945	922, 549	15, 228, 270	1, 738, 944	16, 257, 402
1944	925, 818	15, 060, 403	1, 729, 945	16, 036, 848
1943	850, 576	14, 454, 638	1, 649, 254	15, 374, 698
1942	594, 260	11, 634, 288	1, 383, 827	12, 545. 610
1941	533, 498	10, 646, 947	1, 324, 381	11, 596, 188
1940	462, 360	9, 219, 496	1, 226, 245	10, 087, 548
1939	444, 947	9, 018, 316	1, 195, 026	9, 879, 244
1938	425, 324	8, 545, 930	1, 161, 380	9, 421, 075
1937	412, 091	8, 349, 773	1, 124, 548	9, 221, 517
1936	402, 605	7, 755, 848	1, 096, 721	8, 646, 885
1935	406, 174	6, 875, 182	1, 075, 139	7, 717. 154
1934	393. 425	6, 291, 556	1, 048. 101	7, 147, 416
1933	386, 713	6, 071, 512	1, 027, 046	7, 037, 982
1932	395, 543	6, 303, 573	1, 014, 354	7, 228, 151
1931	384, 333	6, 321, 861	974, 115	7, 155, 976

This is by no means a picture which condemns the present system of free medical practice and of independent community hospitals. Those who would risk the destruction of that system by deliberately enforcing its exchange for one whose unvarying record in other countries has been bad in every respect may be motivated by a real desire to improve American health; but they must nonetheless meet the suggestion that the methods which they propose appear to be founded on ignorance and a failure to understand all of the implications of their proposals.

The selective service rejections

So much has been made and continues to be made, in many cases by those who should know better, of the alleged 5,000,000 rejections in selective service because of remediable defects, that the facts on this matter should be recorded here, in order that this false but persuasive argument may no longer have any weight with Congress. Conclusive and detailed evidence, by medical men of the highest character, has been placed before the Senate committees which in the past 2 or 3 years have been holding the exhaustive hearings referred to, to the effect that these rejections for remediable defects are several million less than charged, when analyzed, and that there is in the whole matter no relationship to the question of the character, cost, and availability of medical care. In fact, one of these medical men, Dr. Maurice H. Friedman, of Washington, D. C., pointed out that in many large groups of rejectees their handicaps, instead of being due to lack of medical care, were due precisely to the fact that they had had medical care. Said Dr. Friedman:

"In the first place, a great many of the defects discovered and listed have very little significance to health. That is not only my opinion but it was repeatedly pointed out in the official bulletins of the selective service statistics.

"Over one-half of the defects listed are structural abnormalities rather than diseases. They might be minor things. A man might have the tip of one finger knocked off or something of that sort. Of the remainder of all these defects, a significant number are related to education rather than to medicine or health.

"Considering only the structural abnormalities, it is a bit ironical that rather than being the result of a lack of medical care, many of these defects are the direct result of medical care. For example, amputations are frequently done as a lifesaving measure or for surgical or medical purposes. Amputations, therefore, are the kind of defect which is a direct result of medical care, not the absence of medical care. Surgical perforations of the middle ear are another example of a medical care which produces a defect for the relief of a disease. We have many other examples.

"The fact that diabetics live long enough to be registered by a draft board is only due to our medical services. They are then recorded as a defect. Every child with rheumatic fever nursed into adult life by skillful medical care will live with a defect. Every invalided infant who survives the tetralogy of Fallot by skillful surgery will increase the recorded number of rejectees. We might ask ourselves: Is a corpse healthier than a rejectee with diabetes?" (Pt. 4, hearings before a subcommittee of the Committee on Labor and Public Welfare, U. S. Senate, p. 2129.)

Dr. Lowell S. Goin, of Los Angeles, appeared before the Senate Committee on Education and Labor on April 17, 1946, and made a statement on this and related subjects which is reported in part 2 of the committee's report of hearings, beginning at page 623. He pointed out many obvious factors contributing to the actual total of 4,217,000 rejectees which have no relation to the need for or quality of medical care, such as the inclusion of 444,800 "manifestly disqualified," the armless and the legless, the totally blind, the totally deaf, and the like, with this comment:

"What medical care could have made this group whole? How shall the amputated leg be restored, and who knows how to cure optic disease? The modern concept is that mental disease is largely a constitutional inborn inability to cope with reality. What has medical care to do with it? Five hundred eighty-two thousand and one hundred were rejected for mental deficiency. * * * Even a very slight knowledge of eugenics will persuade anyone that this group does not constitute a medical-care problem. Together, these three groups (idiots, imbeciles, low-grade morons) reach a total of 1,727,600, or more than a third of the rejectees. If they are now excluded, there remain 2,462,500, a little less than one-half of the famous 5,000,000.

"Three hundred twenty thousand of these were rejected for musculo-skeletal defects. That is the congenitally short leg, the club foot, the withered arm, the absence of a half vertebra and the consequent crooked back. How, I ask, would medical care have restored these unfortunates to usefulness? Two hundred and eighty thousand were rejected for syphilis. Treatment for syphillis is offered freely everywhere. As a matter of fact, our statute books are simply loaded about syphillis prevention. I doubt that there is a community in which a syphilitic may not receive treatment from a department of public health. One wonders how compulsory health insurance would have eliminated this group.

"Two hundred and twenty thousand were rejected for hernia, probably for hernias so severe that the Army was unwilling to attempt repair. I mean by that that likely these were bad hernias, because I did think the Army repaired some. Hernia is the result of a congenital defect in the inguinal or femoral canal, presumably due to a defect in the germ plasm. If such a defect exists, its bearer is likely to have a hernia and medical care has nothing whatever to do with the occurrence of hernia."

Pointing to the eye defects which are largely congenital, and computing a total of about 1,000,000 men suffering from these last three groups of defects causing rejections, Dr. Goin commented:

"The rejections which might be due to a lack of medical care are thus reduced to about 1,500,000, or about one-third of the shocking figure of 5,000,000. Although it is quite problematical whether any program of medical care would have altered substantially this figure, we may rest upon it, confident that the figures fall a good bit short of establishing an urgent need for the enactment of compulsory health insurance."

The detailed analysis by these brilliant medical men of the selective service figures destroys completely any save an imaginary basis in these figures for the Federal plan, and justifies the sugestion that any person who hereafter refers to them in support of compulsory health insurance does so either in ignorance or in bad faith. None the less, such references will undoubtedly be made. Informed Members of Congress will know how to evaluate them.

Medical care in these United States is not perfect; it is only the best in the world. It is, of course, not everywhere instantly available, without money and without price, to all comers; but it can be had. Its superiority to any government-controlled plan is literally beyond expression.

THE AMERICAN HOSPITAL SYSTEM

The hospital system of the country is essentially simple, but is not always fully understood, although the facts are authoritatively and in great detail recorded each year in the study published by the American Medical Association entitled "Hospital Service in the United States." Most of the figures referred to herein are taken from that work covering the year 1947.

For most people the only need for hospitalization arises in connection with serious illness, surgery, or maternity. These cases are cared for in general hospitals, and it is in this category that the great majority of the group of community institutions known as voluntary nonprofit hospitals falls. In addition to these nonprofit voluntary hospitals there are also general hospitals operated by various governments (Federal, State, county, city) and those operated by private owners for profit.

Since, as stated, it is the general hospital, regardless of ownership, in which most people receive needed service, it is these hospitals which handle much the greatest part of all hospital service, in terms both of numbers of patients and of patient-days of care. They handled in 1947 14,665,195 patients, who received 166,717,765 days of service, a handsome total for the 4,539 hospitals involved. That patient-day total is considerably over one hospital day for every man, woman, and child in the country.

There is another large group of hospitals which cares for the chronic or long-term patient, the two largest classes involved being tuberculosis and mental cases. Typically these hospitals are operated by Government, chiefly by the several States; and since for various obvious reasons the care of these patients has long been recognized as a governmental responsibility this entire group of 1,737 hospitals is not taken into account in this study, nor is their 1947 record of 1,164,319 patients.

How about payment?

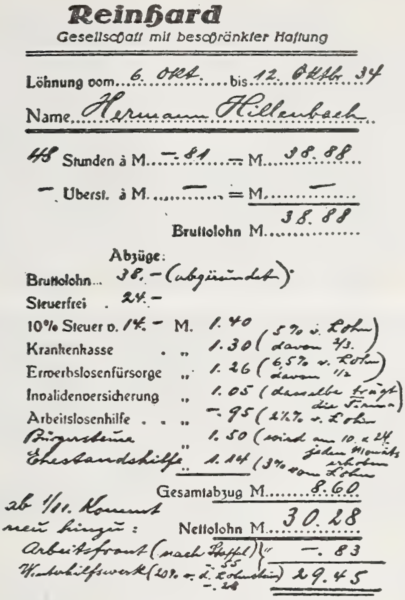
The question of payment for hospital care thus narrows down to the nearly 15,000,000 patients who were cared for in the general hospitals; and since it is this same question of payment, by or for the patient, which looms largest in the broad proposal that for all who work payment should be insured through a Federal tax, one point should be emphasized. It is that for the large number of patients cared for in the general hospitals operated by various governmental agencies the taxpayer pays. The patient in such hospitals (the Veterans' Administration hospitals, for example, or the typical city hospital) is virtually always there as the ward of the Government operating the hospital. He is cared for without charge, therefore, in the proper discharge of the Government's responsibility to him and to the community.

In 1947 the volume of general hospital care handled in these tax-supported hospitals ran to the following figures:

Government	Hospitals	Beds	Average census	Births	Admissions
Federal	317	132, 258	96, 294	46, 048	1, 179, 560
State	57	21, 599	15, 484	50, 134	353, 899
County	267	43, 994	32, 662	109, 332	717, 921
City	286	51, 736	41, 278	191, 539	1, 144, 613
City-county	42	8, 297	5, 958	32, 605	184, 429
Total	969	257, 884	191, 676	429, 658	3, 580, 422

These totals are impressive, especially when considered, as they should be, in relation to the fact that they relate almost entirely to the groups which cannot afford to pay for service in the voluntary nonprofit hospitals. This is true of very nearly all of these patients except veterans entitled to service without charge in veterans' hospitals because of service-connected disabilities. The entire costly and generally efficient system of tax-supported hospitals was established and is being continually expanded and operated for the purpose of caring for that part of the public with low or no income, including the group known as the medically indigent, which consists of the self-supporting to whom the cost of so-called catastrophic illness is too heavy a burden.

This care is universally accepted as a community responsibility, and in all of the larger cities and the more thickly populated counties it is met by the facilities of the hospitals established and maintained for that explicit purpose, as the above figures indicate. In addition to this extensive care for the patient who cannot afford to pay, the voluntary hospitals also provide a widely utilized service for the low-income group, free or below cost, with some payment either by the patient or from tax sources. Since it is largely to the group thus especially provided for that much of the concern expressed by proponents of the Federal plan is directed, it is reasonable to suggest that the Congress take all of these facilities into account.



Reinhard
Gesellschaft mit beschränkter Haftung

Löhnung vom 6. Okt. bis 12. Oktbr. 34

Name Hermann Hillenbach

48 Stunden à M. -.81 = M. 38.88

- Überst. à M. - = M. -

Bruttolohn M. 38.88

Abzüge:

Bruttolohn... 38.- (abgerundet)
Steuerfrei . 24.-
10% Steuer v. 14.- M. 1.40
Krankenkasse . „ 1.30 (5% v. Lohn davon 1/3.)
Erwerbslosenfürsorge „ 1.26 (6,5% v. Lohn davon 1/2)
Invalidenversicherung „ 1.05 (dasselbe trägt die Firma)
Arbeitslosenhilfe . . . „ -.95 (2½% v. Lohn
Bürgersteuer „ 1.50 (wird am 10. u. 24. jeden Monats erhoben
Ehestandshilfe „ 1.14 (3% vom Lohn

Gesamtabzug M. 8.60

ab 1/11. kommt neu hinzu:

Nettolohn M. 30.28

Arbeitsfront (nach Staffel) -.55 } „ -.83
Winterhilfswerk (20% v. d. Lohnsteuer) -.28

29.45

A German worker's pay slip, taken from "Will America Copy Germany's Mistakes" by Gustav Hartz, which shows 22 per cent deductions for social insurance

The fact is that while the plight of those who cannot afford to pay has been cited as one of the strongest reasons for the Federal plan, this plan would have a rather painful effect upon such of them as are employed to the extent which would subject them to the proposed gross-income taxes, since they would lose this much of their inadequate incomes for the purpose of providing payment for hospital care which they now receive to a very considerable extent for nothing. The problem offered by these who have no income at all, the completely indigent, has not yet been given any considerable degree of attention by those who think that the Federal Government has a responsibility for the care of individual health. It is a subject which may be commended to the attention of Congress, and it is not in any necessary degree related to the imposition of a compulsory health-insurance plan upon those who are not indigent.

A factor which also deserves serious consideration by Congress is that which is involved in the Federal proposal to make eligible for care in other than Government hospitals, through compulsory insurance, many thousands who are now adequately and properly cared for in their local tax-supported institutions. These institutions, which are naturally jealous of their long-established function and of their place in the hospital field, must be taken into account from all of the angles involved. There will always be a need for their services, even under the Federal plan, but this need would certainly be diminished to the precise extent that low-income patients were unfairly taxed and then thrust into the voluntary nonprofit hospitals.

Should taxpayers everywhere, large and small, be asked to contribute through new and potentially unlimited taxes to a system which would to a considerable extent remove responsibility and control from local taxpayers? The answer may depend upon the point of view, but the American point of view has always been that local self-government and local responsibility for the care of those in the community unable to look after themselves are for every possible reason to be preferred to the distant authority and the distant tax collector.

The reasonable conclusions on the general subject are admirably stated in the Brookings Institution report of February 1948:

"The United States has some individuals and families not possessed of the resources to enable them to pay for adequate medical care. In the future, as in the past, provision must be made for them through public funds or philanthropy. The evidence suggests that many of them are elderly, impaired, or underendowed, or are widows or deserted women or their dependents. It is doubtful if they could be effectively covered by compulsory insurance because they would lack the means to attain and maintain an insured status.

"The large majority of American families have the resources to pay for adequate medical care if they elect to give it a high priority among the several objects of expenditure. The issue is not whether they can afford medical care but whether they should be compelled by law to pool their risks and to give payment for medical care a top priority. The major alternative for people with ability to pay is to leave them free to determine for themselves what medical care they desire and whether they will pool their risks through voluntary arrangements."

THE VOLUNTARY NONPROFIT HOSPITALS

The voluntary nonprofit community hospitals, as stated above, are those which care for most of the self-supporting population when hospital care is needed. They comprise the group most completely independent in every way, most characteristic of the American spirit in that they were in every instance founded by leaders of the community to meet the needs of the community; and they are virtually unanimous, in the same spirit of independence and community control in which they were founded, in their opposition to a Federal plan which would make practically all of their patients Federal patients.

These hospitals fall into two groups—the church hospitals and the local nonsectarian community hospitals. Their service in 1947 is shown by the following figures:

Type	Number	Beds	Average census	Births	Admissions
Church	924	130, 653	109, 648	946, 158	4, 454, 767
Nonsectarian	1, 578	167, 390	131, 686	1, 118, 280	5, 297, 145
Total	2, 502	298, 043	241, 334	2, 064, 438	9, 751, 912

It might be added here that another group of general hospitals comprises those under private ownership, operated for profit, and performing a useful service in many localities. They number 1,067, and in 1947 served 1,332,498 patients, this very considerable number presumably paying their own way, with or without some prepayment assistance.

As the figures relating to the great nonprofit group clearly indicate, these hospitals, founded and operated as independent community services, and having about 300,000 beds, are actually carrying the lion's share of the general hospital load. Of the total admissions to general hospitals, 14,665,195, these church and nonsectarian community institutions handle, for example, just about two-thirds, as against the one-third handled by all other general hospitals, governmental and proprietary. Of the total of 2,837,139 births in hospitals of all types, their proportion is even higher—over 72 percent. Incidentally, official estimates declare that 82 percent of all live births in the United States in 1947 were in hospitals, as eventually of course it is hoped all births may be; but the present record is a magnificent achievement of the American system of hospital and medical care as it is, and eloquent proof of the fashion in which it is serving the people.

The patients in these hospitals are for the most part pay patients, sent by their physicians or surgeons. Some have private rooms, for which they pay more than actual cost to the hospitals, because they want complete privacy or some other aspects of luxury care. A large proportion, to an increasing extent Blue Cross subscribers, since these prepayment plans now cover the country, occupy beds in rooms with one to two or three other patients, where the charges are lower than for private rooms; and others are in the large wards, where many of them are cared for without any charge or at rates considerably below cost, But all who enter the doors of these hospitals are cared for, and their doors are never closed.

For some people, notably those who occupy private rooms, the bill involved in the complex of services offered by the hospitals (bed and board, general nursing service, laboratory, X-ray, operating or delivery room) may be taken in stride. For most, however, either careful saving in advance of the contingency or some form of prepayment is highly advisable. People save for vacations, for Christmas; they do not always save for serious illness or surgery, because these matters are not predictable and, of course, are not anticipated with pleasure if at all. None the less, the citizen who knows that accidents may happen and that death and taxes—especially taxes—are certain is to an increasing extent taking care of the needs of his family for hospital care by some form of insurance.

Blue Cross plans and the commercial insurance companies offer various means of prepayment which are everywhere available, the latter also covering medical and surgical care, for which on a voluntary nonprofit basis the Blue Shield plans sponsored by the doctors are increasingly available. Taking into account all of the methods by which the self-supporting and self-respecting American may, exercising his own choice and consulting his own means, arrange for the insurance of his hospital, medical, and surgical care in case of need, over 61,000,000 persons are thus to some extent protected.

An estimate of the total situation might be attempted along these lines: Covered in some sort of prepayment plan, 61,000,000; indigent or medically indigent who actually received hospital care (1947 admissions to government hospitals plus care in voluntary hospitals), about 5,000,000; able to pay without insurance protection, perhaps 10,000,000; total, 76,000,000. Subtracting this from the total population of 147,000,000, that would seem to leave about 71,000,000, including heads of families and their dependents as well as the unmarried adults, or in the neighborhood of 20,000,000 families. It should not be forgotten, either, that included in the total population are the 24,000,000 persons who according to the recent Hoover report receive more or less medical and hospital care from the Federal Government. It is a question, therefore, how many members of the 20,000,000 families estimated above have needed medical or hospital care, or, needing it, fail to secure it, out of their own resources or from the facilities at their disposal as citizens. Roughly 1 in 9 of the population actually did receive hospital care in 1947. In any event, only a relatively small fraction of the group would need the protection they had deliberately refused to provide for themselves; and in case of need the typical case is certainly that they are cared for at their own expense, as a ward of government, or as part of the free service accorded by the present system.

National income, taxes, and debt, 1929 to 1949

Year	(A) National income (in billions)	(B) Federal budget (in millions)	(B) As per-cent of (A)	Federal debt (in millions)
1929	$87.4	$3,300	3.8	$16,931
1933	39.6	3,900	9.9	22,539
1934	48.6	6,011	12.3	27,053
1935	56.8	7,010	12.3	28,701
1936	66.9	8,666	12.9	33,778
1937	73.6	8,177	11.2	36,425
1938	67.4	7,239	10.7	37,165
1939	72.5	9,027	12.4	40,440
1940	81.3	9,297	11.4	42,968
1941	103.8	13,765	13.3	48,961
1942	136.5	34,290	25.2	72,422
1943	168.3	79,702	47.5	136,696
1944	182.4	95,573	52.3	201,003
1945	181.7	100,398	57.2	258,682
1946	179.3	63,714	35.5	269,422
1947	202.5	42,523	21.0	260,400
1948	[1] 227.3	42,200	19.2	260,200
1949 [2]	220.0	45,000	20.5	260,200

[1] Projected figure.
[2] Estimate.

As to those of the working population whose incomes are so limited that it is said, with sympathy, that they cannot afford either to pay as they go or to pay Blue Cross and similar premium charges, they are to be compelled to pay Federal charges, which may count to 5 or 6 percent, or more, of their pay, out of their own pockets, in addition to all other taxes, whether they can afford it or not. Of this seriously illogical and self-contradictory proposal, more later.

The Blue Cross plans

Speaking of prepayment arrangements, look at Blue Cross, because it is by all odds the most successful and popular of all hospital prepayment methods—guaranteeing the needed service instead of providing a limited cash payment—and because it is hospital-sponsored and nonprofit. The totale coverage of Blue Cross (United States and Canada) is now 31,841,136, of which total 29,468,675 are in this country. The growth of Blue Cross from 1937 to 1948, from 1,164,126 to the total indicated, is certainly responsible for the fact that during the same period general hospital admissions rose from 8,349,773 to 14,665,195. (See charts.) In 1947 Blue Cross plans paid the hospitals for services rendered to subscribers $211,392,000, covering 21,700,000 days of care.

When it is considered that this has been accomplished in about 12 short years, and that every State except Nevada is now represented in the roll of some 90 approved plans, it must be said at least that it is a remarkable and commendable achievement. Even "the enemies of Caesar must say this," and the Federal Security Administration's representatives have from time to time paid tribute to the accomplishment, which, however, they regret they must brand as inadequate, and which must, they feel, be wiped out by the compulsory blanket substitution of a Nation-wide Federal system.

They suggest some such employment for Blue Cross plans, thus rendered futile, as their use in collections or bookkeeping; but such suggestions need not be taken seriously. The enactment of Federal legislation setting up a tax system for the support of national health insurance would by necessary consequence destroy Blue Cross, for the obvious reason that nobody would need to be twice protected against the cost of illness, nor would anybody voluntarily pay twice for such protection. Blue Cross would be dead, slain by the deliberate action of the Federal Government. Surely Congress will desire to think of this long and seriously before signing the death warrant.

There is another factor, characteristically American also, which will have to be taken into account while universal health-tax legislation is being considered. It is the fact that organized labor (which in general officially favors the Federal plan because half the cost would be taken from the employer) is rapidly leaning not only to the idea that arrangements for health and retirement purposes are appropriate items in collective bargaining, but that Blue Cross gives the best hospital deal; as it does.

The United Mine Workers, for example, have been conspicuously successful in this respect, with a welfare tax per ton of coal mined which has produced a very handsome fund. Just as the pensions made possible by this fund ($100 a month) are very considerably in excess of the pathetic retirement payments of Social Security, its ability to provide medical care for eligible workers, through Blue Cross or otherwise, might well be much greater than that of even a Federal tax-based fund. Certainly the case for welfare arrangements in collective bargaining would be seriously weakened should a Federal plan be adopted, for here again the employer, who would have to pay both ways, would be well within reason in objecting to paying twice. Thus the Federal plan would inevitably tend to destroy welfare provisions arrived at through collective bargaining by organized labor, precisely as it would destroy Blue Cross and other voluntary plans.

An eloquent tribute was paid recently to the part which Blue Cross plans have played in enabling organized labor to bargain for protection against the costs of hospitalization, by Harry Becker, director of the Social Security Department of the International UAW-CIO, Detroit. Mr. Becker said:

"What labor wants for the one out of four families who are going to have a hospital bill this next year is a slip on leaving the hospital which reads: 'Your hospital bill has been paid in full.' There was a time when this goal was 'sky-pilot' thinking; but today this idea does not belong in the stratosphere—we have demonstrated that through collective bargaining we have a practical approach to the problem of financing on a prepaid basis full prepayment of the costs of hospital care for every working man and his family. This demonstration has been made possible because of the kind of joint labor-Blue Cross cooperation existing in such instances as the Michigan Hospital Service and the International UAW-CIO."

In the light of a very recent development, the completion of plans under which employers operating in more than one State will be able to enroll their employees in Blue Cross on a national uniform basis, if desired, as in commercial insurance plans, Mr. Becker's further remarks are especially interesting:

"As unions move into social security as a major collective bargaining issue we are looking to Blue Cross to take the next important step. This step is a national

Blue Cross plan which will provide for universal coverage with the same standard of 'full-payment' benefits for all of the employees of a single employer even though the employees may be living in a number of different States. This means Nationwide cooperation among all Blue Cross plans to assure national coverage of workers, wherever they may live, when a national labor-management program is set up under collective-bargaining contracts whether negotiated in Detroit, Pittsburgh or Los Angeles. Labor is expecting that Blue Cross will not delay taking this next step—now!"

Blue Cross has taken this step, as stated, largely in direct response to the reasonable demands of labor for national Blue Cross coverage, with complete service contracts guaranteed (as they are) by the voluntary nonprofit hospitals who are the actual partners of Blue Cross. The destructive effects of a compulsory Federal plan would thus involve directly not only Blue Cross, but the results gained in its utilization in industry through collective bargaining for hospital-care arrangements.

Would this be wise, or just? Is it necessary? Is it desirable?

THE FAILURE OF GOVERNMENT MEDICINE

Henry, the young Virginia orator of the Revolution, remarked on an historical occasion: "I have but one lamp by which my feet are guided, and that is the lamp of experience. I know of but one way of judging the future, and that is by the past."

This is a sound view. Holding up the lamp of experience, therefore, in connection with the question of whether under Federal control a compulsory system of individual health care should be imposed, and attempting as well as may be to judge the future by the past should such a system be established, several matters suggest themselves for consideration. One concerns the operation of hospital and medical care by Government, particularly by the Federal Government, in this country, and another concerns the operations of social-insurance systems, including health care, in other countries, such as Germany, Great Britain, and New Zealand; all of which have furnished a record of experience in this line.

Remember the Navajos?

In this country there is an exceptionally impressive example of Government medicine as it actually works, in the case of the Navajo Indians, as reported about a year ago to the Department of the Interior by Dr. Haven Emerson, one of the country's most widely known and experienced physicians, on behalf of the Association of American Indian Affairs. This report, which was widely publicized, covered in detail the disgraceful conditions prevailing as to health among the 81,000 Navajos, wards of the Federal Government ever since their final conquest in the seventies.

Dr. Emerson's report stated that with grazing for their flocks arbitrarily reduced, also by Federal authority, the Navajos are existing on 1,200 calories a day, less than the Germans received immediately after the war; that many of them are so weak because of this inadequate diet that they cannot stand sustained exertion: that there is one social-service worker for the entire tribe; that more than 10,000 are eligible for old-age assistance, aid to dependent children and aid to the blind, but are not receiving these services; and that mortality rates are so high, resulting from the total or partial lack of the medical services they need and are therefore entitled to, that Government economy in this respect appears to be purchased routinely with Navajo lives. A tuberculosis infection rate 14 times the average of the country as a whole is one pointed index of the situation.

The number of hospital beds in the generally excellent institutions operated by the Bureau of Indian Affairs appears to be adequate: but roads are almost entirely lacking, and the Navajos do not possess cars. The situation, in brief, has been and remains perfect for the kind of active public and individual health care, outside of or in the hospital (including out-patient care), of which the Federal authorities think they should be given permanent and exclusive charge for everybody. But medical care, in particular, has hardly been given at all to the Navajos, the very special wards of the Government.

Apprised of the situation somewhat belatedly, Congress has taken steps to remove this disgrace from the Government's continuing record of ineptitude in health matters; but the facts constitute an unanswerable challenge to the ability of a distant central government to give even minimum health care to the Nation as a whole, since it has failed so miserably in this limited area.

Aside from this curious, significant and depressing instance, and with the qualification that, of course, there are good hospitals operated by government, including the Federal government, and without raking up old ashes—some not so old—to start fresh fires, it must be said that as a rule the voluntary nonprofit community hospital, of which this country fortunately has so many fine examples, averages very much better indeed than the Government hospital. There have been and doubtless still are some hospitals in the voluntary group which are not as good as they should be; but there have been among them no such scandals of corruption, mismanagement and bad service as have risen to the horrified view of the public from the institutions operated by Government at all levels.

It is not always remembered, as an outstanding example of an important aspect of medical care chiefly under Government control, that mental cases are almost entirely hospitalized in tax-supported institutions, State or Federal, and that the record of these institutions, for whatever reasons, has furnished the unpleasantly authenticated background for such recent studies as "The Snake Pit." As a leading psychiatric authority commented 2 years ago (Dr. C. Charles Burlingame, Hartford, Conn.). "For over a hundred years 95 percent of the practice of psychiatry has been State medicine," adding that "before going further along the road toward political handling of medical care, the people should demand that the ability of State medicine be demonstrated first in its present responsibilities." Said Dr. Burlingame further:

"Why ask for new worlds to conquer when the obligations already belonging to socialized medicine have been so scandalously neglected? Why ask for more when a concentration of all efforts and resources in this one field which is already the Government's, offers the greatest single opportunity to bring health to the greatest number?"

There has been no adequate answer to this logical question, from any quarter.

The painstaking investigation of the veterans' hospitals, for example, by the American Legion and other organizations of former servicemen, occurred not too long ago for the memory to be quite fresh of the conditions which they revealed. The mess, once revealed, was finally cleaned up by the prompt and aggressive action of the new head of the Veterans' Administration and his able assistants; but the record of what miserable conditions had accumulated over the years, under complete and undisputed Federal control, should not be forgotten. The tendency of hospitals operated or in any sense controlled by Government toward such conditions will always remain, for reasons which everybody understands. The curious thing is that, this being the case, there are people who are not only willing, but anxious and determined, to turn over to governmental control, in the fullest sense of the word, all individual health care. Congress will have to consider with the utmost seriousness this tendency, which was explicitly referred to some time ago by a great hospital authority, the late Dr. S. S. Goldwater, a personal friend of the late President Franklin D. Roosevelt.

Dr. Goldwater was commissioner of hospitals in New York City long enough to find out something about the effect of political control on hospital care. He spent the last years of his life as president of the vast Associated Hospital Service, the metropolitan New York Blue Cross plan, and incidentally in fighting bitterly the then new threat of a Federal compulsory plan. In an address on this subject delivered in Philadelphia in 1942, the year of his death, he said:

"Local organization and control will produce the best results in hospitalization, and any Federal approach to interference with the fiscal affairs of hospitals, leading eventually to control by a central Government bureau, would be a tragic affair for the people of this country. There is justification for the interest of a humane government in the question of whether hospital service has been made available on suitable terms to the great mass of the people, but this inquiry should also take into account the fact that the voluntary, locally directed hospital service plans have made Government intervention unnecessary.

"Assumptions that we must do as other countries have done, regardless of our achievements, are certainly not justified, especially in a country where freedom is valued and where the principle of local self-government is supposed to be sacred. Even the different sections of our country differ in various ways, so that an actually even performance, uniform everywhere, could hardly be secured if it were desired. I don't want it; we could have it only under strict Government control, and it would be on a level far below what can be achieved under the system we have been developing for so long and so successfully.

"Moreover, failure in a locality, if it must occur, is not the tragic thing that a country-wide failure would be. Hospitals must be left free to take such action as their communities require, without having to wait for approval from Washington based on imperfect knowledge of local conditions and needs."

Speaking specifically of hospital conditions under Government control, of which his experience in New York gave him ample knowledge, Dr. Goldwater said, with the utmost earnestness:

"My own experience in New York showed me how far short Government hospitals can fall from the perfection which has been attributed to them. Perfect conditions do not exist anywhere, and even in New York, where as head of the city's hospitals, I worked under conditions as favorable as can be expected in Government, the story has not been told of the impediments placed by Government circumlocution in the way of anybody attempting to administer a large group of hospitals from a central office. The system as a whole failed to accomplish what I had in mind for the city because of the onerous conditions under which Government work of all sorts has to be done. It could hardly be otherwise if the Federal Government attempted to exercise any measure of control over the voluntary hospitals, as it would inevitably do, sooner or later, under the plans proposed by the Social Security Board."

The fact is that not enough has been said about the tendency of medical service to degenerate under government control in this country as well as everywhere else. Dr. Goldwater's comments are to the point, and they are supported strongly by some 1946 remarks by Dr. Frank H. Lahey, of Boston, the famous head of the Lahey Clinic, who ran the system of medical-officer procurement for the Federal Government during the war. After pointing to the fact that the great loss in medical care under government is the disappearance of quality competition, Dr. Lahey said, addressing a group of surgeons:

"Veterans' care is an example of Government-directed medicine. I say this with regret, because, after all, who is responsible for veterans' care? We are. It is only recently that we have shouted about it. We have known how bad it was, and we have not done anything about it. It has been under our eyes for years. I doubt if there is a surgeon here who has not been rescue man for a veterans' hospital, and has undone and done over things that have made him know that the medicine and surgery in many of them were not good. It has been excellent in some of them, and therefore we must not damn the whole thing for a relative percentage. But the point is this: If you want a living example of Government-directed medicine, look at the Veterans' Bureau as it was. It was Government-directed medicine at its worst. It is not fair to say that it was Government medicine, as it will be under the present national program of veterans' care, but it is an actual completed experiment of what a national program of Government-directed medicine did degenerate to. It is for that reason that I plead that it is so easy to promote a plan and not foresee its possible future consequences.

"I should think that this country after its experience with trying to legislate morals and sex and an appetite for alcohol would have learned by now that there are some things that must come by evolution and education and not by compulsion. They cannot come by compulsion."

The Congress will undoubtedly give evidence of this character, coming from men of great ability, wide experience, and unimpeachable standing, the thoughtful consideration which it demands; and in this connection, the personal observation of many Members of both Houses will stand them in good stead as to the quality of Government operation or control of various activities.

It is of course true that the Federal Government would not at first literally take over the operation of the voluntary nonprofit hospitals, although the British experience shows clearly that eventually that would have to be expected. It is asserted by those who favor the plan that it concerns only the payment of the bill, and that otherwise the people and the institutions rendering individual health service would remain precisely as now. Both President Truman and the Federal Security Administrator, among others, have declared that they do not wish to injure or interfere with the voluntary hospitals, and that a compulsory Federal plan would not do this.

Unfortunately, that view takes no account of the fact that with the payment of all medical and hospital bills, for everybody who works, in the hands of a Government agency, control would follow as a matter of inevitable direct consequence. It is not only that "he who pays the fiddler calls the tune." It is the fact that where a Government agency disburses tax funds it has a duty to inspect the goods or audit the services for which the funds are paid. Whether this duty is intelligently and ably performed or not, it must be performed, and the fact of its performance would constitute effective control.

The mass of Federal regulations having the force of law which would necessarily flow from the attempt to operate a Federal health-care plan would be enormous, detailed, explicit, and crippling. The fees and charges allowed would be only the beginning. Every move of the patient, the doctor, the dentist, the nurse, the hospital admitting office, and the rest of the personnel engaged in its necessary activities would have to be covered in detail, as would the whole record of many millions of workers and their employers. That is why estimates of the additional Government personnel run as high as 1,500,000, based on actual experience abroad indicating 1 additional employee for each 100 persons covered by the system.

There is actually no way under a Government system to avoid this. It has to be attempted, wherever Government payments and controls enter. It includes the inescapable fact that functionaries almost automatically try to broaden their scope and importance, regardless of efficiency and cost. It is always confusing and hampering and in the peculiarly and essentially individualistic work of caring for the sick it has always proved to be deadly. It is known as red tape. It repels the best type of professional man, and the simple fact is that any such system in this country would prevent the expansion and improvement of medical care, instead of aiding it, because the men who would make the best doctors would not under such a system choose to become doctors at all.

Hence the opposition

It is of course this consideration, with all that is implied in it, which accounts for the consistent and uncompromising opposition to any compulsory Federal health insurance plan of the American Medical Association, the American Dental Association, the American Hospital Association, the American Protestant Hospital Association, the Catholic Hospital Association, and innumerable allied organizations. They have in their meetings, at public assemblies, in the press, and before committees of Congress, stated repeatedly and in detail the explicit and reasonable grounds on which they most earnestly believe that Federal compulsory health insurance would mean Federal control, and that Federal control would mean inferior service to the American people, at vast and unpredictable cost.

There is no question about this virtually unanimous opposition on the part of the professional and technical groups who under the Federal plan as now would have to do the work of caring for the health of the people. It has been urgently, eloquently, and repeatedly expressed. Why have the views of these people, who must be regarded as the only available experts in medical and hospital care and the means of paying for it, been so deliberately and extensively ignored by the advocates of the Federal plan? This is a question which demands an answer, if there is one.

In all other affairs where national legislation is considered, the advice of the people who know, the people who do the work, is not only sought but followed. In the legislation concerning farms and mines and factories, Congress would consider itself, and would properly be considered, as failing in its constitutional function as representative of all of the people, and in its duty to consult the facts and the wisest counsel on the situation, if it did not secure and act upon the views of the qualified and experienced workers in the field involved. Would a completely new and radical farm program be adopted by Congress against the advice and wishes of farmers and farm-organization leaders? Would a system of control and payment covering all coal mining be imposed under Federal legislation over the opposition of both mine operators and coal miners? Of course not. The questions are ridiculous.

But it has been proposed time and again, for reasons which on their face are entirely inadequate to support the idea, to impose upon the hundreds of thousands of experienced, able, and intelligent people whose lives are devoted to the medical, dental, hospital, and other individual health care of Americans a system to which they are utterly opposed, on what must be accepted as sound grounds. And this system, condemned as inefficient and costly by the professional and technical personnel most intimately acquainted with the whole subject, is also to be imposed upon the people as a whole, with all of the risks involved of inferior service and increasingly burdensome cost.

Would Congress be wise to do this, in any situation short of a national emergency? Should not the informed opinion of the whole group of workers in the field be consulted and heeded, even against the weight of whatever pressures and arguments may be brought forth by the Government and other interested groups supporting the Federal plan? Should not the unhappy experience of other countries, far gone in paternalistic and collectivist controls of all sorts, be sufficient in itself to bar such moves in a Nation "conceived in liberty"?

Germany, a pioneer in "social insurance," Britain, and New Zealand have all furnished examples of what happens under government control of individual health care, and these are worth a brief review, since it may give some additional warning against the dangerous folly of imposing a compulsory health-care system in the United States.

GOVERNMENT HEALTH INSURANCE IN ACTION

The experience of other countries, ranging from that of Germany for over 60 years to New Zealand's much more recent but similar record, shows that—

1. Costs skyrocket to incredible levels, due to overuse and other abuses.
2. Those who render the service tend to become cynical and careless in their role of government dependents, as users do in their desire to get everything they have paid for, and the quality of all services deteriorates rapidly.

An authoritative study of the German system by Gustav Hartz, a Berlin labor economist, was published in 1935 by the Pennsylvania Self-Insurers Association of Philadelphia, and its statement of the record has not been challenged seriously. Since the war began in 1939, the study is probably the best prewar examination of the German system before the Hitler regime consumed everything. It is of course a matter of historical fact that the beginnings of social insurance in Germany were made by Bismarck, probably for the purpose of defeating the Socialists by outdoing them in this respect. At any rate, the system was established.

A broad introductory comment by the author is worth quoting, since it applies to the whole idea of social insurance, where Germany's experience was as so long and so discouraging:

"Of all the risks in social insurance only old age, death, and the number of dependents can be exactly established. These are therefore the only cases in which an unobjectionable actuarial basis and an unquestioned legal claim are possible. Everything else is hazy and uncontrollable."

Thus, with an average payment to those receiving old age or disability insurance of $7 per month, the system also produced a rise in the average number of days of sickness (inability to work) from 5½ to 28 per year. Some of the very human factors contributing to this result are described in the following language:

"The sick insurance provides the workman with medical attendance free of charge, with medicine and other necessities, and with an allowance. Anyone will at first sight consider this as a great blessing for the workmen as well as for national health. The reality, however, is very different.

"Dread of illness obsesses most people, and this has been pressed into a system 'illness made easy' by which the will to be well is strangled. The doctor is consulted a dozen times where once would be sufficient, the insurance pays. The prescribing of medicine, bandages, etc., is desired. When they have been obtained they lie about until they are no longer fit to be used and must be thrown away—the insurance pays. Besides, it is nice to get something in return for the premiums paid year in and year out. Excessive 'overdoctoring' is the result and fear of illness that shakes the will for recovery, the best aid to health. Pretenders and hypochondriacs are bred and the use of medicine becomes excessive."

As a result, efforts at regulation were naturally made, with the cause and the result of the situation reported in these words, following the comment that the "social budget amounted to 2,100,000,000 marks in 1913, but in 1930 this budget reached 18,000,000,000 marks":

"In the first months of the year the applications for cures to the disability and employees' insurances pour in because many are anxious to take their summer holiday at the expense of the social insurances. Matters soon made an extensive controlling system necessary. This ended in badgering all persons concerned. Patients are visited in their homes by controlling officials who have to convince themselves that the patient is really ill and not doing any work. The patients are therefore allowed certain hours for going out by the dictors.

"The sick insurance engages so-called confidential doctors who have to submit the patient to a final examination to see whether he is too ill to work. The results of such examinations are to a great extent startling. Here is one instance from among thousands: 2,008 patients were ordered to appear for a final examination. Eight hundred and sixteen of them at once declared their complete recovery; 289 were found to be well by the confidential doctor. So nearly 50 percent were not ill at all.

"The confidential doctor is, so to say, the medical policeman, who not only controls the patients but also his fellow doctors who are treating them. The genuine patient is justly indignant to find that the existence of his illness is doubted, and that he who has always paid his premiums regularly and has a right to demand conscientious attendance is considered a cheat.

"This system, together with the rest of the bureaucratic apparatus, has wedged itself between doctor and patient, completely destroying the patient's confidence in his physician, which greatly retards all recovery. The sound idea of sick insurance has become thoroughly unsound, and the harm it does far outweighs its advantages."

But here is the net result in terms to be borne clearly in mind when the modest cost estimates are heard for an American Federal social security system expanded to cover all individual health care:

"Premiums started on a modest basis. The first were 1½ percent for the employee and three-fourths percent for the employer. *Today the entire premium averages almost one-fifth (20 percent) of the amount of wages, and even for miners it is nearly 30 percent.*" [Emphasis supplied.]

What right or logic is there in any assumption, by anybody, that results in this country would be different, either in cost or in the deterioration of service, should the United States, in a supremely ironical about-face, follow Germany's old example?

And in Great Britain—

It should be remembered that while health insurance was initiated in Great Britain in 1911, under David Lloyd George, with a system of pay-roll taxes to support it, the recent complete socialization of all medical and hospital care in that country discards all pretense of insurance, and makes individual health care something like a government monopoly, which incidentally stopped short only of taking over the Catholic hospitals. While this result may be assumed to be a part of the rapid trend toward state socialism in Britain, it may also be inferred that the first step, compulsory health insurance, leads by natural consequence to the last, government monopoly.

At any rate, some dispatches from London since the new system went into effect are at least informative, and bear a strong family resemblance in their report of what is now going on there to what happened in Germany. For instance, according to the Journal of the American Medical Association's London correspondent, August 14, 1948:

"In their enthusiasm for medical socialism its advocates entirely overlook its drawbacks. In a letter to the Times a physician who has had much experience of it in the panel system shows how much time is wasted. At least one-third of his patients come in for no medical purpose at all. They come for certificates of a great variety or for the repeat of a prescription. Here lies the main difference between panel and private practice and the main reason for so much unnecessary work, which clutters up the office and prevents good work for those needing a physician's care. The private patient, having seen his doctor, can get his prescription repeated as often as necessary by simply going to the pharmacist, but the panel prescription can be dispensed only once. For every fresh bottle the panel patient must visit the physician to obtain a fresh prescription, wasting his own time and the physician's time. It may be asked: 'Why not make a new regulation abolishing the difference?' The answer reveals another drawback of medical socialism. The panel patient gets his medicine free, and with the universal craving for bottle of medicine of the hypochondriacs of the English masses, the waste which exists under the panel system would be multiplied."

Commenting on this situation, admittedly a disturbing proof of the unfortunately general eagerness to claim too much of anything that is offered without limit, Minister of Health Bevan is quoted as sayin:

"Because things are free is no reason why people should abuse their opportunities. This is a very great test of the maturity of the British people, insofar as they have all of the resources of the medical profession at their disposal without charge. The general practitioner has a very great responsibility. Overprescribing can be as bad as underprescribing. Some general practitioners are very conscious of the impressiveness of the long lists of drugs in their prescriptions on the psychology of their patients. We want the general practitioner to prescribe what he believes is necessary, and put nothing in his way. *But we want to impress upon him that it is not a good thing to evoke merely a psychologic response by prescribing too expensive drugs.*" [Emphasis supplied.]

"We want to impress on him?" A stern warning from the Minister of Health, himself not a physician, to all general practitioners, about prescrbiing "too expensive drugs"? This is indeed government medicine in operation. But, after all, with expenses going up and excessive use of both doctors and drugs recorded, naturally the Minister of Health is concerned at the situation, as well he may be. The reader is inescapably reminded of the pathos of Sir Stafford Cripps' weary restatement of the facts of life to the British unionists, when he pointed out that wages had to come out of production, and that wiping out profits entirely would add only four-pence a week, or some such trifle, to wages.

It is reported that "the rush for spectacles has been so great that it has overtaken productive capacity," and that (this too according to Mr. Bevan) the number of prescriptions of all sorts dispensed has reached a phenomenal level, at a rate twice that under the former national health insrance plan. An annual total of 140,000,000 to 150,000,000 prescriptions was estimated in consequence. The demand for dental care, a comparatively minor item in the health system, it was thought, has reached a cost of over $600,000 a day, or $180,000,000 a year, as compared with the estimated cost of $28,000,000 a year. In brief, all of the estimates, of use and therefore of cost, were far too low. This is the sort of thing which must be taken into account in any reasonable effort, if indeed such an effort can be made reasonably, to estimate the cost of complete individual health care in this country.

Among the resulting complications, entirely aside from the matter of the effect on government finances, now substantially supported by contributions from this capitalistic land, is the overcrowding of all facilities, with some consequences of the most tragic sort. It is a curious reflection on the operation of a compulsory health-care system in England for 37 years that it did not produce by direct result enough hospital beds, enough doctors, or enough dentists for the country. Thus a question anxiously placed before the legal department of the British Medical Journal, according to its issue of November 22, 1947, growing out of the grave shortage of hospital beds after 36 years of compulsory health insurance:

"Question: A. B. is referred by his medical attendant to a particular consultant at a hospital. A diagnosis of early carcinoma of the stomach is made and confirmed. The patient is advised to have an operation, to which he agrees, and he is put on the waiting list for admission. Presumably the consultant has entered into a contract with the patient and his doctor to carry out the treatment. The patient is not admitted for 6 or even 12 months, *and the growth becomes inoperable.*" [Italics supplied.]

The legal obligations involved are not such, the Journal's expert is said to have advised, that any liability results, since "neither the consultant nor the hospital is required to do the impossible." But the patient, it must be assumed, died without the benefit of the surgery which might have saved his life. Perhaps such a case could occur in this country, but the odds are against it. American hospitals, voluntary and tax-supported together, rendered in 1947, 444,288,585 days of patient care, and handled in addition at low or no charge over 40,000,000 out-patient calls, where dangerous conditions calling for further treatment, including surgery, can be caught in time. In this country if a bed is needed for a serious case, the bed is there. This does not appear to be so under the highly socialized British system. So much for Government control.

Still, there is something to be said for the national health service, compelled, both by the excessive and unnecessary demands which free service always produces and by the same inadequacy of facilities which under similar handicaps would certainly appear in this country, to let a cancer patient die when he might have been saved. It has recently been announced that the Ministry of Health, no doubt after consulting both its financial situation and the demands of the public, is issuing an average of 200 utility toupees weekly, at a cost of $40 each. To meet this demand for the toupee as an indispensable health adjunct, 23 wigmakers, participating gleefully in the scheme, are working night and day, with an estimated total potential production of approximately 100,000 wigs. That is $4,000,000; and another $400,000 out of the apparently unlimited resources of the national health account (if not unlimited why this absurdity?) will be devoted to the cost of cleaning wigs for those beneficiaries fortunate enough to have two, since one of these may be cleaned and dressed at Government expense every 2 months. Wigs are supplied by the Health Ministry in all sizes and colors, and women are offered five different models.

But people wait until they die for hospital beds; and this, too, is Government medicine.

And in New Zealand—

In this small and highly socialized country, with a homogeneous population (except for the remaining native Maoris) which is might be supposed would have a fair chance of avoiding the major difficulties of placing all medical care under Government control, 7 years of experience have shown once more that there are no exceptions to the rule of increased cost due to excessive use of all facilities, and decreasing standards of care. So serious, in fact, have these and related defects in the system become that the Government and the medical profession are earnestly attempting to arrive at some practical revision of the program. Meanwhile, the major problem facing Government and people is indicated by the single simple fact that the tax bill for medical services rose from less than $8,000,000 in 1942 to over $20,000,000 in 1947. The cost of drugs rose from $2,000,000 in 1943 to over $4,000,000 in 1947. Thus the medical-care program contributes a growing share of the social-security budget, which is now one-third of the national budget, and therefore of the total tax load.

Moreover, while reports indicate that many doctors, and not by any means the best or the leaders of the profession, were earning fantastic incomes by vigorous exploitation of the system, both the profession as a whole and the public have found it unsatisfactory. A striking omission from it, also, is that even the excessive cost being experienced does not cover the cost of major surgery, the most serious burden to the average citizen, and the one which he is typically most anxious to cover through some form of insurance. Medical care, hospitalization, and drugs are the items covered.

A chief complaint in New Zealand is related to the fact that while all may resort to the doctor at will, with most (but not all) of the cost covered out of the insurance fund, there is no way of making the doctor stay in his office on holidays, week ends and at night. This is attributed in part to the fact that there is no incentive for the doctor to work harder or longer because of his own income taxes, as well as to the amount of work forced upon him during the week. The demand for medical services tripled from 1941, when the system was put in force, to 1945, while many doctors were still with the armed forces, and there were not enough at home to meet the demand. When the war was over, with the demand for care still rising, the costs rose to the serious level referred to. Whether the Government will find a solution satisfactory to its financial advisers as well as to the public and the medical and dental professions remains to be seen. Suggestions from the Government to the doctors, in a semiconfidential vein as contrasted with its promises to the public, of reduced care, were properly rejected by the doctors. Recall Mr. Bevan's peevish comment about excessive use of expensive drugs in Great Britain. These systems seem to work the same way everywhere. That is to say, they produce excessive use, a correspondingly serious and unwarranted drain on contributors and the Government finances, and unsatisfactory service.

The present American system shines brightly by comparison with anything they have or have ever had in medical care in Germany, in Great Britain, or in New Zealand.

THE COST OF A FEDERAL SYSTEM

There is literally no way of finding out what the proposed compulsory Federal system for the care of individual health would cost, especially when the inevitable tendency toward excessive demands on the free services promised is considered. Estimates may be made, however, and these of course should be based upon such facts as are available, and not upon sheer optimism or a desire to make the prospective bill seem less than it will probably be.

Even with the health-insurance plan in mind, or perhaps with it especially in mind, the first necessity confronting the Congress is that of framing the legislation under which the coverage of the existing social-security system will be expanded to take in the groups not now included, among which are the farmers and other self-employed, members of the armed forces, and the employees of nonprofit institutions. This, it is estimated, will produce a total under the system, including dependents, of about 120,000,000 persons, or 85 percent of the population. This is to all intent universal coverage.

At the same time the problem is to be faced, as it must, of making the system meet more nearly, if possible, the broad promise of social security implied in its title by providing benefits which are not so low as to compel the beneficiary, as at present, to apply for old-age assistance in order to avoid starvation. On this there is no argument whatever, as the facts on the OASI payments now made speak for themselves, and the Federal Security Administrator was very recently quoted to the following effect: "Today the average amount of old-age insurance paid to elderly couples is $39.30 per month. The present scale of payments was fixed in 1939, but since then the cost of living has increased nearly 75 percent, and the cost of food, over 100 percent. Today old people who are entirely dependent upon their social-security payments are actually enduring slow starvation."

That estimate of the situation is not exaggerated. It should be added, moreover, that in the case of the elderly couples mentioned, unless both man and wife are over 65, which of course is not always the case, the only payment is to the man, and that its average is now around $25 a month. No such amount would have furnished as much as a bare subsistence in 1939, either, so that even then the promise of security under the system was a delusion. The delusion has merely become more evident with the increased cost of living. The whole situation has been recorded in immense and painstaking detail in Issues in Social Security, the report of the Calhoun social security technical staff to the Committee on Ways and Means, ordered by the Seventy-ninth Congress. None of the facts can be disputed.

This is all emphasized, for the attention which it powerfully demands from Congress, not only because it happens to be true and because the proposed remedial legislation will heavily increase the individual's and the Nation's tax burden, but because it offers an immediately relevant and striking proof of the failure of Government performance to live up to the glowing promise. Here, as elsewhere in the world, the promise is broad, the performance is meager, and while the costs go up and the burden on the economy increases the individual is progressively deprived of any chance to protect his own future. Meanwhile the control of government becomes steadily greater as its provision for its wards becomes more difficult and more expensive.

FIGURING THE TAXES

The present social-security tax of 1 percent each on employer and employee will have to be increased immediately to not less than 1½ percent each, on a base of $4,800 instead of the present $3,000, according to the Social Security Board's own figures. The self-employed, including farmers, may be let off with a tax of only 1½ times the employee rate, instead of double, as it should be, so that this group would be asked to pay 2¼ percent of income up to $4,800 for the present system, providing only OASI and related benefits.

These taxes, chiefly for retirement benefits, on a grossly inadequate basis even if the proposed 50 percent rise is approved, are estimated to produce over $4,000,000,000 a year instead of the present $2,750,000,000; and they will add to the present $10,000,000,000 reserves in the system about $2,000,000,000 a year, up to the time when payments will exceed income, with the growth of the number of beneficiaries, and the Government will have to pay about one-third of the total out of general taxes to be levied on all alike. The Board's own estimates, again, point to an annual cost for the OASI system of 5 to 6 billions in 1960, 7 to 9 billions in 1970, and 9 to 12 billions in 1980. It becomes clear, as these figures are considered, that it really makes little difference how the taxes are levied, since all will have to bear them in one way or another, and the so-called reserves are in simple fact only Government obligations, for the payment of which, when cash is needed, the Treasury will have to provide.

Add to this, then, the proposed health-insurance system. The Board estimates its cost in the first year at four billions, with an additional two billions should a disability insurance coverage be provided. These estimates appear to be in line with a conservative view of limited use of medical and hospital-care facilities, but not at all with the generally recorded fact of excessive use, when the Government is compelled to make good on its promises of unlimited care and medicines for everybody. In Great Britain, for example, in spite of the country's experience of 37 years with health insurance, the cost of the Government's operation of all health care was underestimated for the first 3 months alone at the rate of $372,000,000 a year. An equivalent error in similar estimates in this country, on the basis of relative population, would mean over $2,500,000,000 a year, which might matter.

However, taking the estimates as a basis, at least, of the tax which will in the beginning be asked of Congress for health insurance alone, with increased rates later as rising costs force the issue, 1½ percent each for employer and employee will be added to the social-security taxes and, presumably, for the self-employed another 2¼ percent, all applying to pay or self-earned income up to $4,800. Thus for the farmer who can be shown to have netted that amount, and there are a good many of them, there will be a gross income tax, in addition to all other taxes, of $216 a year, at the beginning. At the higher rates which will almost certainly become necessary as time goes on, the tax will be proportionately higher.

Thus as the very least and lowest, and without taking into account the depressing indications in the experience of other countries that health-insurance cost will be double or triple the highly conservative estimates, the Social Security Board itself believes that taxes will have to be levied annually for its operations, in addition to all other taxes, to the amount of not less than eight billions, with two billions more for disability insurance. That makes 10 billions.

The Congress is to be faced immediately, aside from all this, with the tax and other problems related to a general budget of $45,000,000,000 or thereabouts. The tax bill which will be drawn to meet that enormous sum, without repeating the dangerous resort to deficit financing, will necessarily rely chiefly upon individual and corporate income taxes. These taxes, burdensome as they are when raised to the levels designed to meet such vast budget figures, will receive the most earnest scrutiny from Government experts, including Members of Congress, concerned both for their effect upon the general economy, especially upon industrial productivity and employment, and their impact upon the individual taxpayer.

With the country's now extensive experience in meeting enormous Federal governmental costs at least in part by taxes—the debt of $250,000,000,000 has accumulated in addition to taxes and remains as a continuous threat—realization has become general that there are no new sources of revenue. The only source of revenue is the American citizen. He pays and will continue to pay the entire bill, in his daily expenses, in his production, in the effect upon his and his family's standards of living and their arrangements for the future, as well as in direct taxes.

He has been paying in direct taxes for social-security purposes his half of the current take of $2,750,000,000. Under the new plans for the expansion of the system, not including health insurance, he will be asked to pay half of the increased levy of $4,000,000,000; and yet the payments to the OASI beneficiaries, it must be remembered, will remain so small (50 percent over the present average would be $37.50 a month) as still to force the lucky recipients to accept old-age assistance or stop eating.

Then ask him to pay half of an assessment of another four billions for health insurance, whether he wants it or not, and whether he needs it or not, and still another two billions for disability insurance. Ask him.

There is no need to doubt that many of the proponents of the idea of the Federal Government assuming full charge of individual health care, as of individual security in old age, mean well. But to mean well is not enough, if the results should be disastrous in terms of promises not kept, of the encouragement of abuse of medical facilities, the degeneration and discouragement of the profession of healing, and rising taxes and Government debt. Even the supporters of the Federal plan estimate an eventual cost for the program of somewhere between 15 and 20 percent of pay rolls (Readings in Social Security, Cohen & Haber). The Congress will have to bear all this in mind in attempting to decide wisely whether to embark upon a course so radical, so costly in both money and in the human factors involved, and so unlikely to accomplish the desired results, if experience both in this country and elsewhere means anything at all.

SUMMARY

The reasons advanced in favor of expanding the social security system, admittedly a failure in its operation up to now, to cover individual health care are not sufficient to warrant the serious risks involved.

Government plans for individual health care in other countries have produced uncontrollably excessive demands upon doctors, hospitals, and auxiliary services, without any possibility of reasonable check once the deterrent of individual cost has been removed, and with resulting excessive cost to the insurance fund and to Government.

Medical, hospital, and related individual health services in this country are now the best in the world, under a system which has developed according to the best traditions of the American character; and these services are available to the vast majority of the people, at charges they can pay with or without the increasing scope of voluntary prepayment plans, or without charge. Government may assist, but should not be permitted to destroy, this magnificent system.

Something must be said, in addition to all of the above, of the destruction of traditional liberty which is directly and unavoidably involved in the plan to bring individual health care under Government control by compulsory legislation. There is a point at which the right and the duty of government to legislate, even for the general welfare, conflicts with the right of the citizen to be let alone. Stop signs are necessary on the public highways; but no citizen would permit them to be placed by government on his private road.

The parallel alleged between compulsory health insurance and compulsory school attendance is not accurate. School attendance is required of children, not adults; and it exists only under State law, not under Federal law. When every citizen is required not merely to submit to heavy deductions from his pay for Federal health insurance but to call upon his doctor and his dentist on such dates as may be fixed by the Federal authority, the parallel will be complete, and the compulsory system will have developed to its logical conclusion. Such compulsion as to visits for medical and dental examinations is in fact the only possible way in which the results promised may even hope to be achieved. Will Congress go this far?

Under the still free American system, education of the individual to the desirability of proper professional advice on health matters, so that he may himself voluntarily take advantage of the available facilities, including prepayment for health care, is the only sound and practical and acceptable method.

Liberty is still the dearest possession of the American. Liberty always implies responsibility; and the exercise of responsibility develops ability to meet it, in every aspect of existence, including the care of one's health. The alternative of destroying personal and professional liberty is the alternative of the paternalistic and collectivist state. It is unacceptable to the traditions and the spirit of a free people. It should not be imposed for the purpose of taking over the control of individual health care or for any other purpose.

Mr. Olsen. Also from the Life Insurance Association of America, New York, N. Y., issued January 6, 1949, a report of a survey of voluntary protection built up against the economic hazards of sickness and accident in the United States.

May I make that part of the record?

Senator Murray. Yes.

(The report above referred to is as follows:)

A Survey of Accident and Health Coverage in the United States as of December 31, 1947

(Prepared for American Life Convention, Chicago, Ill.; American Mutual Alliance, Chicago, Ill.; Association of Casualty and Surety Companies, New York, N. Y.; Bureau of Accident and Health Underwriters, New York, N. Y.; Health and Accident Underwriters Conference, Chicago, Ill.; Life Insurance Association of America, New York, N. Y.; Life Insurers Conference, Richmond, Va.; National Fraternal Congress of America, Chicago, Ill.)

HIGH LIGHTS OF THE SURVEY

On December 31, 1947, an estimated total of 31,224,000 workers were insured under some form of voluntary protection against loss of income due to sickness or accident. This represents more than half the 58,000,000 employed civilians in the United States. Also, 52,584,000 individuals were protected by some form of hospital expense coverage; 26,247,000 individuals had surgical expense coverage; and 8,898,000 individuals had medical expense coverage. These latter figures include dependents of workers as well as the workers themselves. The figures in the survey were obtained by a study of all types of accident and health insurance plans, embracing not only those protected by insurance companies but also those covered by the Blue Cross and all the other types of organizations providing this protection.

Even more impressive than the number of individuals covered by the programs included in the survey is the rapid growth that has occurred during the past decade. Because of the many types of organizations writing these coverages and the lack of aggregate statistics for past years, no long-term comparison is possible for the over-all figures. Certain segments of the business, however, indicate how rapid the growth has been. For instance, persons insured for hospital-expense benefits under either group insurance or Blue Cross plans at the end of 1947 numbered 56 percent more than at the end of 1945 and 241 percent more than at the end of 1941. Surgical-expense insurance is a more recent development and has been growing even faster, while medical-expense insurance is the newest and fastest-growing type of all.

INTRODUCTION

In order to secure as accurate a picture as possible of the scope and extent of voluntary protection against the economic hazards of sickness and accident in the United States, several of the insurance trade associations have joined together to make this survey of the country's facilities and accomplishments to date.

Because of the number and variety of the organizations providing such protection, many of which are local in character, the task has been difficult. While the committee has attempted to tap every source of information and secure data on all accident and health insurance plans in operation in the country, it is still probable that some organizations providing benefits for sickness and accidents have not been included and that the survey understates the full extent of accident and health protection in the United States. Many of the figures are necessarily estimates, but every effort has been made to base such estimates upon the best data obtainable.

TYPES OF ACCIDENT AND HEALTH COVERAGE

The principal types of accident and health benefits are:

1. Benefits for loss of income due to sickness or accident, often referred to as cash sickness or disability benefits.
2. Hospital expense—benefits on account of hospital room and board charges and, in most cases, miscellaneous additional expenses.
3. Surgical expense—benefits on account of surgical operation fees.
4. Medical expense—benefits on account of doctors' fees other than for surgery, as well as the cost of special laboratory, X-ray and other examinations. Medical expense benefits range from the coverage of doctors' calls within the hospital to the coverage of home, hospital, and office treatments and examinations.

The last three types of benefits listed above may be provided either through payments to the individual receiving the service or payment made directly to the person or institution providing the service.

SUMMARY OF SURVEY

The following table gives the estimated number of individuals covered by the various voluntary forms of accident and health protection in the United States on December 31, 1947. Details of the sources of the data and methods of compilation will be found in the appendix.

I. Insurance against loss of income due to sickness or accident

(*a*) Insurance companies and fraternal societies	18, 714, 000
(*b*) Paid sick leave—in private industry	4, 560, 000
In civilian government service	4, 490, 000
(*c*) Employee mutual benefit associations	1, 460, 000
(*d*) Union plans and other employer-employee methods	2, 000, 000
Grand total [1]	31, 224, 000

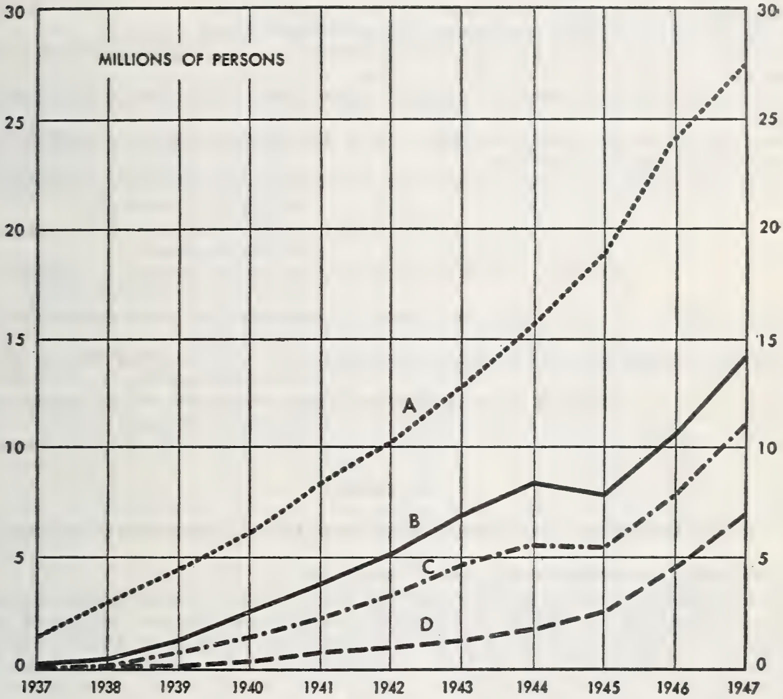
[1] This does not include individuals covered solely by Government insurance under compulsory plans.

II. Hospital, surgical, and medical expense coverage

	Hospital	Surgical	Medical
(*a*) Insurance companies, hospital insurance companies and fraternal societies:			
Personal	10, 548, 000	8, 687, 000	1, 463, 000
Dependents	10, 275, 000	6, 651, 000	606, 000
Total	20, 823, 000	15, 338, 000	2, 069, 000
(*b*) Blue Cross plans and plans sponsored by medical socities:			
Personal	12, 355, 000	3, 260, 000	1, 495, 000
Dependents	15, 631, 000	3, 820, 000	1, 490, 000
Total	27, 986, 000	7, 080, 000	2, 985, 000
(*c*) Other organizations:			
1. Bituminous-coal industry:			
Personal	190, 000	224, 000	224, 000
Dependents	250, 000	300, 000	300, 000
Total	440, 000	524, 000	524, 000
2. Consumer sponsored	1, 600, 000	1, 600, 000	1, 600, 000
3. Industrial, excluding coal mining	1, 260, 000	1, 220, 000	1, 215, 000
4. Private group clinics	375, 000	385, 000	405, 000
5. University health plans	100, 000	100, 000	100, 000
Grand total	52, 584, 000	26, 247, 000	8, 898, 000

GROWTH TRENDS IN VOLUNTARY ACCIDENT AND HEALTH INSURANCE

The chart below shows how rapid has been the growth of certain types of coverage for which comparable data are available for the years of the past decade. These comprise the bulk of the hospital expense and surgical expense coverage.



A. Individuals Covered for Hospital Expense Under Blue Cross Plans
B. Individuals Covered for Hospital Expense Under Group Policies
C. Individuals Covered for Surgical Expense Under Group Policies
D. Individuals Covered for Surgical Expense Under Plans Sponsored by Medical Societies or Affiliated with Blue Cross.

Sources of Data Are Given on Page 15

TYPES OF PROTECTION NOT INCLUDED IN THE SURVEY

Since the purpose of this survey is to measure the extent and growth of coverage under employer-employee and other voluntary programs, individuals covered solely by Government insurance under compulsory plans have not been included in the total number of persons protected against loss of income due to sickness or accidents. However, data have been obtained which indicate that more than 4,000,000 workers were engaged in covered employment at the end of 1947 under the Rhode Island and California cash sickness plans and under the Crosser amendment to the Railroad Unemployment Insurance Act. Of these, it is estimated that about 2.000.000 are counted under one of the voluntary plans covered by this survey, while the remaining 2,000,000 were protected solely by a compulsory plan. Further details concerning these compulsory plans are given in the appendix on page 10.

Also omitted from the survey are various types of protection such as those listed below which were not considered appropriate for inclusion in this study but which, nevertheless, provide many dollars in benefits to the injured and disabled.

Workmen's compensation providing protection to the majority of wage earners against occupational accidents and diseases.

Total and permanent disability benefits included in many life insurance policies.

Commercial accident policies providing disability indemnity and other benefits in event of accidental injuries, approximately 4,000,000 in number.

Commercial accident policies covering travel hazards and other specified risks, over 3,000,000 in number.

Complete medical care for persons in the armed forces.

Complete medical care for persons in public institutions.

Medical care and disability pensions available under certain conditions to war veterans.

Protection under automobile and all other types of personal-injury-liability policies.

Medical payments provisions under many automobile, residence liability, and other types of liability policies.

This survey has been prepared and is submitted by the following committee:

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Vice President and Actuary, Monarch Life Insurance Co., Chairman.

Appendix

PART I. INSURANCE AGAINST LOSS OF INCOME DUE TO ACCIDENT OR SICKNESS

A. Insurance companies and fraternal societies

The number of individuals covered for both sickness and accident disability was obtained from the annual survey made by the United States Chamber of Commerce (*1*). The number of individual policies was reduced by 16⅔ percent to eliminate duplication arising from policyholders who carry more than one policy.

B. Paid sick leave

Many employers have some plan of continuing wages and salaries for a period during the sickness of an employee. While no Nation-wide statistics are available as to the extent of this practice, a number of recent surveys provide the basis for an estimate. Studies made in Illinois (*2*), Massachusetts (*3*), New Jersey (*4*), New York (*5*), and Washington (*6*), based in each case on a survey conducted through a sample of employers, indicate the number of employees covered by group insurance and the number who enjoy paid sick leave and other types of coverage. The figures developed by these surveys are presented in the following table, except those for Illinois which, because of their form, could not be compared directly with the other data. In order to avoid duplication persons covered under group insurance, whether or not also covered by other types of protection, have been included under group insurance only. All persons covered by paid sick leave except those also covered by group insurance have been included under paid sick leave only. Finally, all those counted under either group insurance or paid sick leave have been excluded from the mutual benefit associations and union plan classifications. There is quite a striking similarity in the results given by these independent State surveys.

While these States are not representative of the entire Nation, it seemed reasonable to assume that the proportionate distribution of coverage by type in the rest of the country would be close to the reported distribution for these States. Since the most complete figures available are those for group insurance, the extent of the other types of coverage was estimated by using the group totals as a common denominator.

SUMMARY OF STATE SURVEYS

Distribution of employees with coverage against loss of income according to type of coverage

Type of coverage	Massachusetts	New Jersey	New York	Washington	Weighted average[1]	Ratio to group insurance
	Percent	*Percent*	*Percent*	*Percent*	*Percent*	*Percent*
Group insurance, including combinations with other types of coverage	49.3	56.7	44.4	49.6	48.0	100
Paid sick leave, including combinations with other types except group insurance	40.3	38.4	43.0	41.4	41.5	86
Mutual benefit associations, including combinations with union plans	10.4	4.5	11.7	4.9	9.6	20
Union plans, alone, and other methods	----------	.4	.9	4.1	.9	----------
Total	100.0	100.0	100.0	100.0	100.0	----------

[1] Weighted according to population.

The percentages shown in the last column of the table were applied to the total number of individuals covered by group insurance in the United States at the end of 1945, 5,921,000 (*1*), after deducting 619,634 railroad workers (7) covered by group insurance, since they were not included in any of the State surveys used; 1945 figures were used as a base since the State surveys referred to above were made at approximately this time and since it cannot be assumed that either paid sick leave or mutual benefit association coverage increased during 1946 and 1947 as rapidly as group insurance. Accordingly, the estimate of 4,560,000 employees in private industry covered under paid sick leave, thus obtained, represents the status at the end of 1945. The true figures at the end of 1947 may be somewhat higher due to the increase in private employment during that period.

All Federal Government employees covered by civil service and the majority of State and local government employees are entitled to paid sick leave. The total so covered has been estimated at 4,490,000 on the following basis. Mr. James M. Mitchell, director of the Civil Service Assembly of the United States and Canada (Chicago, Ill.), has estimated that between 65 and 75 percent of all State employees are entitled to sick-leave benefits. From the Municipal Year Book 1947, data given on cities of over 10,000 population indicated that cities employing 72 percent of the total of all employees listed provided sick-leave benefits to all employees, while cities employing 89 percent of all such employees provide benefits to one class of employees, either salaried employees or wage workers. Based upon these indications it was assumed that 75 percent of all city, State, and local government employees enjoy sick-leave benefits.

According to the Bureau of Labor Statistics (*8*), there were at the end of 1947 approximately 1,750,000 Federal Government employees, exclusive of the seasonal employees added in December, and approximately 3,650,000 State and local employees. Counting 100 percent of the former and 75 percent of the latter the estimate of 4,490,000 was obtained.

C. Employee mutual benefit associations

An estimate was determined in this category by the same method as used for the number of employees in private industry enjoying paid sick-leave benefits. The figures from above table indicate that the number of persons who are members of employee mutual benefit associations without any other form of protection equals 20 percent of the number protected by group insurance. Again deducting the 619,634 railroad workers and applying the ratio of 20 percent to the balance we obtain 1,060,000. To this number has been added 403,584 representing the number of railroad employees in railroad relief associations (7). The result, approximately 1,460,000, does not include all members of these associations since the method used excludes those who had another form of protection. Although this calculation produces the estimate number covered in 1945, the same figure has been taken for the status at the end of 1947. In view of the rapid growth in group insurance and the enactment of the Crosser amendment to the Railroad Unemployment Insurance Act, it seems unlikely that much growth has occurred among these associations as a whole.

It is expected that more up-to-date information will be available when the statistical survey now being conducted by the Federation of Employees' Benefit Associations is completed.

D. Union plans and other employer-employee methods

Applying the method used to obtain the number of employees under paid sick-leave plans in private industry and employee mutual benefit associations would indicate only about 100,000 employees covered exclusively by union plans. Other statistics which are available in connection with health and benefit plans of unions indicate a much larger figure. It appears from an examination of the statistics that a very large number of the union members who are entitled to sickness or disability benefits are building trade workers, mechanics, and others who would be covered inadequately, if at all, in any survey conducted through employers. It is also unlikely that employers would know of or undertake to report coverage of employees who are members of craft unions. Since a very large part of union coverage appears to be within the craft unions rather than the industry-wide unions it seems reasonable to disregard any figures on union coverage obtained through employers.

In her report Cash Benefits Under Voluntary Disability Insurance in the United States (*9*), Mrs. Otey estimated that in 1935 between 1,200,000 and 1,500,000 individuals were covered under union plans. In addition to the normal growth during the past 12 years in the numbers covered by the plans in effect in 1935, the establishment of the United Mine Workers Welfare and Retirement Fund has brought disability benefits to approximately 300,000 miners (*10*). Based upon these data and considerations it is estimated that 2,000,000 individuals are covered by union and other employer-employee methods without other voluntary coverage.

E. Compulsory plans

The Rhode Island Unemployment Compensation Board has estimated that 315,000 persons earned sufficient wages in 1947 to qualify for benefits although only 250,000 were in covered employment at the end of 1947. The research section of the California Employment Stabilization Commission has similarly estimated that 3,250,000 persons had established wage credits of $300 or more in appropriate quarters of 19146 and 1947 to qualify for cash sickness benefits but states that analysis at the time an actual claim is filed will show that some do not meet the specific requirements of the act. The number actually working in covered employment in California at the end of 1947 was about 2,473,000 of whom approximately 700,000 were covered by voluntary plans meeting the requirements of the State plan. The Unemployment and Sickness Benefits Analysis Section of the Railroad Retirement Board has furnished the information that approximately 2,270,000 employees earned $150 or more in railroad employment in 1946 and are eligible for benefits during the benefit year July 1947 through June 1948. According to the Bureau of Labor Statistic (*8*) the number of employees of class 1 steam railways at the end of 1947 was 1,331,000 and the number employed in the operation of street railways and busses was 249,000. Some of the latter are understood to be covered by the Railroad Unemployment Insurance Act. In 1945 it was found, as stated, on page 10, that 619,634 railroad workers were covered under group insurance and 403,584 were members of railroad relief associations.

It will be noted that in each of the three compulsory plans there are a large number of individuals who are no longer in covered employment but who may retain some coverage as a result of wage credits granted while so employed. Of these, many may have entered other employment where they are covered by group insurance, paid sick-leave plans, mutual-benefit associations, or union plans. Others are covered under individual policies. Still others have left the labor market, lost their coverage by moving to a different State or country or may have died. Of those in covered employment, approximately 700,000 in California are protected under voluntary plans and approximately 1,000,000 railroad workers, based on 1945 figures, have coverage through insurance companies or mutual benefit associations. A large number of those covered under each of the three plans also carry individual policies. In the absence of any information which would permit an accurate analysis of those covered under these acts, the foregoing information is presented with the conclusion that of somewhat more than 4,000,000 persons engaged in covered employment under these plans at the end of 1947, approximately half have been enumerated under various employer-employee and other voluntary or elective plans while the remaining half are protected directly by a compulsory plan with no other coverage.

Part II. Hospital, Surgical and Medical Expense Coverage

A. Insurance companies and fraternal societies

The extent of protection afforded by insurance companies and fraternal societies against hospital, surgical and medical expense is given in a recent report of the Chamber of Commerce of the United States (*1*). In combining the figures for individual and group coverage, the former were reduced by 16⅔ percent to eliminate duplication of coverage. In addition to the companies and societies included in the United States Chamber of Commerce Survey, there is a group of over thirty recently incorporated hospital insurance companies and associations which issue policies insuring against hospital, surgical, and medical expense. Since these organizations operate as insurance companies, though confining their business to hospital, surgical, and medical coverage, their statistics are not reported by the Blue Cross Commission. Accordingly, a special survey was made by this committee and results obtained were incorporated in the total coverage under this heading, as outlined below.

Number of persons insured by insurance companies, hospital insurance companies, and fraternal societies for the indicated coverage

[000's omitted]

Type	Hospital		Surgical		Medical	
	Personal	Dependents	Personal	Dependents	Personal	Dependents
Group	7,110	7,080	6,529	4,574	852	246
Individual [1]	2,638	2,122	1,783	1,417	508	192
Hospital insurance companies	800	1,073	375	660	103	168
Total	10,548	10,275	8,687	6,651	1,463	606

[1] Reduced by 16⅔ percent to eliminate duplication.

B. Blue Cross plans and plans sponsored by medical societies

Data furnished by the Blue Cross Commission, Chicago, Ill., indicate that in the United States 12,057,085 subscribers and 15,475,484 dependents were protected against hospital expense under Blue Cross plans at the end of 1947.

Approximately 7,380,000 people were covered for surgical expense under plans of organizations sponsored by medical societies or affiliated with Blue Cross plans at the end of 1947, according to a report of the Americn Medical Association's Council on medical service. Of these, approximately 300,000 are enrolled in plans privately insured and included in the insurance company figures given above. This number has, therefore, been deducted from the total, leaving 7,080,000 to be counted in this section. Of this number 1,760,000 are enrolled in plans providing medical as well as surgical care, while 2,715,000 are in plans in which medical care is optional. From a comparison between the 1946 data reported by the council on medical service and Dr. Reed's estimate (*11*) of the number covered for medical care through this type of organization, it appears that, where optional, the medical care benefits are elected by about 45 percent of the membership. Using this ratio it was estimated that 2,985,000 members of these organizations were entitled to medical care. As stated on page 4, the term "medical care" has been used to cover plans varying from in-hospital care only to complete medical care other than surgery. The division of these figures between subscribers and dependents is given in the table on page 5. Three of these orgnizations also provide hospital expense coverage for 298,000 subscribers and 156,000 dependents, which have been added to those covered by Blue Cross plans.

C. Other organizations

1. Plans in the bituminous-coal industry.—A medical survey of the bituminous coal industry reported in March 1947 (*12*), contains the information that more than 70 percent of the miners involved in the survey, which covered a total of 260 bituminous-coal mines throughout the country, are entitled to benefits under medical service prepayment plans and that the estimated participation of the employed miners and their families averages more than 95 percent. Applying these factors to the 337,000 soft coal miners in the United States (*8*), we have an estimate of 224,000 miners covered by these plans; 300,000 is considered to be a conservative estimate of the dependents also covered. The same report shows that 75 percent of the miners included in the survey were eligible for prepayment hospitalization plans and that an estimated 90 percent of these were participating. These ratios would indicate approximately the same number of employees covered under hospital expense plans as are covered for medical expense. Unlike the medical care plans, however, a number of these hospital plans are administered either by Blue Cross organizations or by private insurance companies. Of the 197 plans studied, 14 were operated by companies and 17 by Blue Cross. Since these would be included in the figures of group insurance and Blue Cross organizations, a reduction has been made in the estimates otherwise indicated by these data. In the absence of any other statistical data it has been assumed that the number covered under these insurance and Blue Cross plans would be in the same proportion as the number of plans.

On these assumptions it is estimated that 190,000 subscribers and 250,000 dependents not counted elsewhere are entitled to hospital service under these programs. According to the article cited in part I. D. (*10*), the new miners welfare and retirement fund does not now provide benefits for medical and hospital care. It is stated, however, that eventually it is hoped to extend the Fund's services to provide such care.

2. *Consumer sponsored.*—Preliminary returns from a survey being made by the Council on Medical Service indicate that there are about 170 consumer sponsored prepayment organizations with a total enrollment as of December 31, 1947, of over 1,600,000 individuals entitled to hospital, surgical, and medical care.

3 *Industrial and private group clinic.*—Miss Margaret Klem of the Division of Health and Disability Studies in the Federal Security Agency has reported the following figures for these organizations (*13*):

	Hospital care	Surgical care	Medical care
Industrial	1,419,699	1,379,282	1,386,317
rivate group clinic	375,196	387,696	406,330

These figures show the status early in 1945. However, comparisons between 1943 and 1945 data do not indicate much growth in these types of organizations. accordingly, it has been assumed that the figures for industrial plans and private group clinics are reasonably representative of the volume of coverage at the end of 1947. However, included in the plans classified above as industrial are 18 organizations which, although they serve the employees of industrial corporations, are largely managed by the employees rather than by the employing corporations. These have been included in the survey of consumer sponsored plans made by the council on medical service. In order to use the most recent data available, the figures for these organizations have been left in the consumer sponsored classification and the figures for enrollment in industrial plans have been reduced appropriately.

4. *University health plans.*—Several of the colleges and universities provide comprehensive service for students on a prepaid basis. Dr. Reed's estimate is that 100,000 individuals were covered for each of the services under these plans at the end of 1946 (*11*). The same number has been assumed for 1947.

PART III. ELIMINATION OF DUPLICATION

In the report of the United States Chamber of Commerce on its survey of individual insurance (*1*), the number of policies of health and accident insurance was divided by 1.2, that is, reduced by 16⅔ percent, to avoid counting more than once a person who is insured under more than one policy or who carries individual as well as group insurance. Studies made by individual companies have indicated that this adjustment results in a conservative estimate of the number of individuals insured.

The New York survey by the National Industrial Conference Board (*5*) indicated that the amount of duplication of coverages incidental to employment was minor. This study showed that 557,460 employees were covered under single programs, 52,571 were covered under two programs, and 6,122 were entitled to benefits from three sources, namely, an insurance company plan, a paid sick leave plan, and an employee mutual benefit association. The figures given in the other State surveys also indicated comparatively little duplication.

It should be emphasized, however, that in developing the estimated number of individuals covered under paid sick leave plans and employee mutual menefit association plans, as presented in this report, the figures were so used as to exclude any duplication of plans provided for employees. It is believed that through the use of the factor of 1.2 in connection with individual policies and the method by which the other figures were derived, duplication has been effectively eliminated. Of course, many of the 31,224,000 individuals estimated to be protected against loss of income are also included in the 52,584,000 who have hospital coverage. No attempt has been made to measure the duplication between these coverages since they are separate and distinct.

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(*2*) Illinois State Legislature: Report of Joint Legislative Commission on Disability Unemployment Compensation in Illinois, pp. 55, 60. Springfield: May 15, 1947.

(*3*) Commonwealth of Massachusetts: Report on Sickness Benefits by State Advisory Council, Division of Employment Security, p. 52. Boston: December 4, 1946.

(*4*) State of New Jersey: Cash Sickness Benefits: Fourth Report of the State Commission on Postwar Economic Welfare, p. 8. Trenton: April 9, 1946.

(*5*) National Industrial Conference Board, Inc.: Compulsory Sickness Compensation of New York State, p. 120. New York: 1947.

(*6*) State of Washington: Disability Compensation Study, pp. 12, 14, 22. Olympia: Office of Unemployment Compensation and Placement, December 1, 1946.

(*7*) Data on railroad workers covered by group insurance and by railroad relief associations courtesy of Edward D. Brown, Consulting Actuary, Chicago, Ill.

(*8*) Bureau of Labor Statistics, United States Department of Labor: Employment and Pay Rolls, Detailed Report, December 1947. Washington: February 17, 1948.

(*9*) Otey, (Mrs.) Elizabeth L.: Cash Benefits Under Voluntary Disability Insurance in the United States. Bureau Report No. 6, Bureau of Research and Statistics, Social Security Board, Federal Security Agency. Washington, 1940.

(*10*) Corson, John J.: Miners Lead Way in Social Security. Washington Post, July 18, 1948.

(*11*) Reed, Dr. Louis S.: Blue Cross and Medical Service Plans. United States Public Health Service, Federal Security Agency. Washington: October 1947.

(*12*) Coal Mines Administration, United States Department of the Interior: A Medical Survey of the Bituminous Coal Industry. Washington: 1947.

(*13*) Klem, (Miss) Margaret C.: Prepayment Medical Care Organizations, Third Edition Bureau Memorandum No. 55, Bureau of Research and Statistics, Social Security Board, Federal Security Agency. Washington: June 1945.

SOURCES OF DATA FOR GROWTH TRENDS CHART

B and C, 1946 and 1947: Group Insurance and Group Annuity Coverage United States Business. Life Insurance Association of America, 165 Broadway, New York, N. Y.

B and C, prior years: Reference (*11*), p. 306. Number of dependents with hospital coverage estimated for 1940 and prior, and dependents with surgical coverage estimated for 1941 and prior.

A, all years: Blue Cross Commission, Chicago, Ill.
D, 1946 and 1947: Council on Medical Service, American Medical Association, Chicago, Ill.
D, prior years: Reference (*11*), p. 146.

Mr. OLSEN. The survey indicates that on December 31, 1947, an estimated total of 31,224,000 workers carried some form of voluntary protection against loss of income due to sickness or accident. This represents more than half of the 58,000,000 employed civilians in the United States.

Even more impressive—certain segments—indicate how rapid the growth has been. For instances, persons insured for hospital expense benefits under either group insurance or Blue Cross plans at the end of 1947 numbered 56 percent more than at the end of 1945, and 241 percent more than at the end of 1941; surgical expense insurance is a more recent development and has been growing even faster; while medical expense insurance is the newest and fastest growing type of all.

Bests Index (1946 ed., pts. 1 and 2, pp. 112 to 121, inclusive) lists over 80 insurance carriers providing individual hospitalization contracts with their costs, hospital indemnity, additional benefits, limitations and exclusions.

Bests A. & H. (pp. 122–124) lists over 100 insurance companies writing and providing hospitalization contracts for group; family or individuals.

With your permission, sir, I would like to submit copies of these phtotostats for the record.

Senator MURRAY. All right. It doesn't cost much to print these records at all, just a few hundred thousand dollars. If you have copies of them we could use for the committee and if they are brief it would be all right to print them but if you have any lengthy documents just file them for the record.

Mr. OLSEN. I believe you will find in the Congressional Library you have copies of them. It will be easy to refer to them.

Senator MURRAY. That will be all right.

Mr. OLSEN. I hope you don't think I am trying to do anything that will add to Government expense.

Senator MURRAY. Of course if they are printed in the record it would be very convenient for us but if they are lengthy I would prefer to have them just filed for the record.

Mr. OLSEN. I can well realize what they cost, because they cost us $2.40 apiece.

(The photostats referred to will be found in the files of the committee.)

Dr. Alfred P. Haake, economist-consultant to General Motors Corp., Chicago, Ill, speaking at the Ohio Hospital Association Convention, Columbus, Ohio (March 23–25, 1949) warned that—

> If the Federal Government socializes hospitals and doctors, other professions and business in general will almost be sure to follow.

He further stated:

> In order to preserve and improve the high standards of our hospitals, it is vital for us to retain individual intiative and enterprise as a basis upon which to conduct our hospitals.

Dr. Paul R. Hawley, chief executive of the Blue Cross and Blue Shield Commission, speaking at the same convention in Columbus, said compulsory health insurance has—

> invariably substituted bureaucratic administration for personal attention to patients.

He called it a "product of Communist ideology" and said Lenin described socialized medicine as the "keystone of the arch of the Socialist state."

General Hawley, chief medical officer in the European theater of operations during World War II charged compulsory health cost Europe the world leadership in medical sciences.

Compulsory government health insurance, he went on, is identified with all the—

> bankrupt nations in Europe which are surviving today only because the United States is a free-enterprise Nation.

Dr. Hawley was also the principal speaker on May 17, 1949, at the Hotel Biltmore, New York, where he addressed a group of medical men, hospital officials, and Blue Cross personnel on the occasion of the fourteenth anniversary of the Associated Hospital Service (New York's Blue Cross plan) and the celebration of New York's enrolling its four-millionth member.

New York's record of the growth of Blue Cross and its usefulness as well as its public popularity and acceptance is indicated by its 40,439 enrollment at the close of 1935; by 1940 the total had risen to 1,248,495; 5 years later in 1945 there were 2,226,523 satisfied subscribers. This total had increased to 3,626,321 persons at the close of 1948 and on May 17, 1949, New York's Blue Cross enrollment had reached the four-millionth mark—4,000,000 members, ample proof that New Yorkers were enthusiastically for voluntary hospital prepayment plans. Without the benefits of Blue Cross and Blue Shield many of the persons voluntarily acquiring this protection for themselves might, in my opinion, have become charges of the city.

There are 85 approved Blue Cross plans in operation in the United States—1 in Puerto Rico; Canada incidentally has 5 Blue Cross plans.

But for the advent of World War II there would have been more Blue Cross plans and an even larger number of subscribers enrolled.

Dr. Hawley, speaking to his audience of the national picture from its modest beginning 20 years ago until the present:

> It has pleased its over 34,000,000 subscribers, and that has excited the admiration of millions of other Americans. It continues to fulfill its primary purpose with ever-increasing efficiency.

Incidentally, I have here under date of May 27, 1949, a release that indicates that the enrollment figure for the Blue Cross estimated as of May 27, 1949, is in excess of 34,500,000. The enrollment figure for the Blue Shield as of March 31, 1949, less five plans which have not reported is 11,335,476.

Dr. Hawley continued:

> The events of the past few years, however, have placed an added responsibility upon both Blue Cross and Blue Shield. Because of the unique success that has been theirs in their own fields, they have now become by common consent the

> agencies for demonstrating to the American people that voluntary organizations, operating at local levels, are able to solve great social problems.
>
> The great need of the moment is the reeducation of our people in the importance of preserving the American tradition of individual and community effort upon a voluntary basis, and in the hidden dangers that lie in social improvement through compulsion, however beneficent, by a distant government. No agency is in as good a position to do this as are the great voluntary nonprofit plans for the prepayment of medical and hospital care; and we, in Blue Cross, shall have shirked our duty if we fail to do this.

However, Dr. Hawley continued:

> Compulsory health insurance will be an invitation for every neurotic, every malingerer, and every chiseler to occupy the time of doctors and the beds of hospitals.

In addition to the over 34,000,000 persons covered by Blue Cross there are additional millions (allowing for some overlapping) that are covered by hospital insurance companies, fraternal societies, insurance companies, bituminous coal industry, industrial, private group clinics, university health plans, and others that bring the total number of persons covered to upward of 55,000,000 persons.

Surely that is evidence of the desire of American citizens and workers to voluntarily provide for medical care and hospitalization.

The enactment of any compulsory health-insurance plan would place a burden upon our American workers that would act as a millstone about their necks, and would be disastrous to everyone.

Gentlemen of the committee, we need and welcome your help and guidance, but compulsion is not the way. Compulsion is unacceptable.

Thank you for permitting us to submit this report of the American Protestant Hospital Association for your consideration and study.

Senator MURRAY. Thank you very much. Are there any questions?

Senator DONNELL. Just a very few. When were you president of the American Protestant Hospital Association?

Mr. OLSEN. 1942 and 1943 when we met at the Jefferson in St. Louis in your State.

Senator DONNELL. Was Reverend Marshall elected at that time to succeed you?

Mr. OLSEN. No. Dr. Chester Marshall was nominated at Philadelphia. He came in in 1949. I forget at the moment what city the convention was in.

Senator DONNELL. He is the president?

Mr. OLSEN. He is the present president.

Senator DONNELL. You quoted as follows on page 1 and I ask you whether you concur in this statment of his:

> There is no doubt in my mind that our association would vote unanimously its disapproval of bill S. 1679 introduced by Senator Thomas and others, providing for compulsory health insurance; nor do I have any doubt but that strong approval would be forthcoming for either the Hill bill or the Taft bill, S. 1581.

Do you concur in that statement of Reverend Marshall's?

Mr. OLSEN. Yes, Senator Donnell.

Senator DONNELL. That is all, Mr. Olsen.

Senator MURRAY. Thank you. The next witness will be the Rt. Rev. George Lewis Smith, president of the Catholic Hospital Association.

STATEMENT OF RT. REV. MSGR. GEORGE LEWIS SMITH, PRESIDENT, CATHOLIC HOSPITAL ASSOCIATION OF THE UNITED STATES AND CANADA

Monsignor SMITH. Mr. Chairman and members of the committee, I am Rt. Rev. Msgr. George Lewis Smith, president of the Catholic Hospital Association of the United States and Canada, and appear on behalf of our association.

We have approximately 800 hospitals with over 130,000 beds and bassinets under Catholic auspices in the United States. In 1948 almost 4,000,000 patients were admitted to our Catholic hospitals—3,904,000 out of a total of about 15,160,000 patients admitted to all general hospitals. In other words, more than one out of every four patients admitted to any general hospital in the United States, including Federal and State institutions, was admitted to a Catholic hospital, so you can realize that we have a significant interest in a national health program.

The administrative board of the Catholic Hospital Association has considered and discussed the problems and objectives inherent in a national health program at our meetings, conferences, and conventions for the past several years. During the current year we have given much of our time, thought, and effort to this important matter. We have conferred with representatives of the bureau of health and hospitals of the social action department of the National Catholic Welfare Conference and the National Catholic Welfare Conference and the National Conference of Catholic Charities and have reached a consensus of opinion expressing a constructive viewpoint. We have published a joint statement entitled "A Voluntary Approach to a National Health Program" which I ask to be incorporated in full in the minutes of this hearing.

Senator MURRAY. It will be incorporated.

(The joint statement is as follows:)

A VOLUNTARY APPROACH TO A NATIONAL HEALTH PROGRAM

(By Bureau of Health and Hospitals of the National Catholic Welfare Conference, the National Conference of Catholic Charities, and the Catholic Hospital Association)

FOREWORD

The immediate problem under consideration in the following pages is that of developing an adequate national health program. Interest in the subject has become quite intense and widespread. There has been much discussion and much controversy; but unfortunately there has been also much confusion. The confusion arises in large part from the tendency to oversimplify the problems involved and to assume that the cost of medical care is the only obstacle in the way of a great improvement. The lack of institutional facilities and professional personnel has been greatly underestimated by reason of the emphasis placed on the former. In itself the latter is a primary obstacle and equally in need of remedy if the quality of medical care is not to deteriorate into a mere increase in the quantity of patients. A sound national program should provide for the elimination of both obstacles.

The controversy revolves in large part around the issue of an exclusive and compulsory Government health insurance system versus private and voluntary effort supported by Government assistance instead of control. Many competent authorities fear that an exclusive state system under a compulsory tax will necessarily involve a loss of freedom for the voluntary health agnecies and put an end to private initiative to the ultimate detriment of the health of the Nation. There is no controversy or disagreement concerning the advisability or advantage of a prepayment plan to meet the cost of medical care. Acceptance of such plans is practically unanimous. The division of opinion concerns the question whether there should be an exclusive state monopoly or whether there should be a cooperating partnership between the Government and voluntary health agencies. A right approach to the problem depends not only on a correct analysis of the concrete situation, but also on a correct social philosophy. The rights and duties of society, the state, and the individual must be considered in relation to one another.

Society is a much broader and more comprehensive concept than that of the state. Government is indeed a necessary agency of society, but it is not the only one. There are many others. Because man is a social being he enters into association with others in order to achieve the benefits which are comprehended in the category of social welfare. These associations of a voluntary nature have as legitimate a right to exist as the state itself, provided they serve the common good. The state has a definite responsibility to help protect and promote the health of the Nation inasmuch as the Government is charged under the fundamental law with the duty of promoting the general welfare and inasmuch as the Government alone has adequate resources to implement a comprehensive program. Voluntary agencies, however, have a definite right and responsibility to exercise an important function in planning as well as in executing such a program. It is socially undesirable to neglect the contribution of either the one or the other.

Individualism as a philosophy of life has been discredited, not only because it has failed in practice, but because it stems from a false concept of human nature. Man has a twofold nature, both individual and social. His personal dignity and sacred rights originate in the fact that he is created as a distinct, intelligent and responsible person, with a destiny of his own. His full development as a human being can be achieved only in as far as he is a member of society and only in as far as the obligations of social justice and social charity are fully activated. Ethical and religious ideals which furnish the highest motivation in the care of the sick as in all social service can function more effectively in voluntary associations than through the medium of the modern secularist state.

The Bureau of Health and Hospitals of the Social Action Department, N. C. W. C., the administrative board of the Catholic Hospital Association, and the directors of Catholic Charities have given careful consideration to the varied phases of a national health program, and in formulating their conclusions they approach the problem not from a negative but from a positive viewpoint. They recognize the existence of social responsibility but at the same time they reject the concept of an exclusive state responsibility for the health and well-being of the American people. They reaffirm their conviction that a partnership between the state and voluntary associations provides the better solution and is more consistent with our democratic processes. Monopoly means control: partnership means freedom. They entertain the hope that the following statement will throw new light on the subject and that a genuine cooperation of all parties at interest will produce a constructive program adapted to the needs of the Nation and effective in promoting the highest standards of health and well-being.

Most Reverend KARL J. ALTER,

Bishop of Toledo, Episcopal Chairman, Bureau of Health and Hospitals, Social Action Department, National Catholic Welfare Conference, and Chairman, Administrative Board of the Catholic Hospital Association of the United States and Canada.

PREAMBLE

During the past several years, legislative proposals have been introduced into the Congress calling for a compulsory Government health insurance system. President Truman, in his address on the state of the Nation, January 4, 1949, for the third time requested Congress to enact legislation in favor of a compulsory health program for the people of the United States of America. In order to evaluate the proposals it is highly important that we make a clear and definite distinction between the general objective, namely, the health and physical well-being of the Nation and the specific legislation which is proposed to implement this policy. There is a sound and valid distinction between a national health program and the proposed compulsory Government health insurance law.

There is very little difference of opinion concerning the main objective, namely, the need and importance of promoting the health of the people of this country by prevention and by providing adequate care in periods of sickness or disability. There is, however, a decided difference of opinion with regard to the methods that should be followed in securing this objective. One school of thought places a comprehensive and almost exclusive responsibility on the Federal Government and minimizes the function of voluntary organizations, such as hospital associations, medical associations, Blue Cross, Blue Shield, Medical Indemnities, etc. There is another school ofthought which follows the social principle of "subsidiary function" and places in consequence chief responsibility on voluntary associations and private initiative without, however, excluding Government financial support.

Evaluation of Needs

Many competent authorities reject the policy of a compulsory Government insurance program which sets up definite controls (either expressed or implied) over hospitals, medical practitioners, dentists, nurses and the auxiliary services concerned with the problems of health and sickness. Health care in the legislation proposed becomes practically a Government monopoly. It is recognized that some effort has been made to provide for voluntary and private initiative in determining the program but it reduces such efforts to a minor or subordinate role.

On January 16, 1949, an independent and highly competent investigating agency, namely, the National Research Council, stated that compulsory health insurance is not a major factor in the health of a country. "The principal factors in health are an adequate number of doctors, nurses, and hospitals; adequate nutrition and high living standards." The report continues with the statement: "There is a good reason to believe that better (health) results might be expected from paying careful attention to the improvement of living standards, to good nutrition, the elimination of economic and social inequalities bettwen races, development of medical facilities, preventative health measures, and other factors which directly affect the health of the people."

Another highly competent investigating agency, the Brookings Institution, in its report on "The Issue of Compulsory Health Insurance" published in 1948, includes the following in its conclusions.

"It is apparent that the United States under its voluntary system of medical care has made greater progress in the application of medical and sanitary science than any other country. * * * There is every reason to believe that these trends will continue unabated under our present system of medical care.

"Compulsory health insurance would necessitate a high degree of governmental regulation and control over the personnel and the agencies engaged in providing medical care. This field of regulation and control would be far more difficult than any other large field previously entered by the Government, and past experience with the governmental regulations and control in the United States causes doubt as to whether it encourages initiative and development.

"The experience of the United States since 1932 seems to have demonstrated the wisdom of these recommendations of the majority of the members of the Committee on the Costs of Medical Care. It would seem unwise at this time to substitute for these developments a system of compulsory health insurance by national law which would have the unfortunate tendency to freeze policies and eventually retard medical progress."

Unwarranted Government monopoly

It is not so much the principle of taxation for health protection which is opposed. Rather it is the monopoly which would be the inevitable result under the Government system, and the misnomer of calling the tax an insurance. Insurance, according to accepted terminology, implies uniform and specific benefits supported by standard adequate reserves proportioned to premiums; definite actuarial basis in determining cost of benefits; voluntary election of the protection offered. The proposed compulsory Government health insurance system has none of these features.

Opposition is expressed against Senate bill 5 because it could not fulfill its promises under existing shortages of personnel and institutional facilities; because it would not by adequate action cure these shortages; because it would necessarily create a huge bureaucracy to administer its complicated regulations; because it would impose unequal burdens for construction of institutional facilities on the incomes of people in the lower income brackets; because it would destroy voluntary agencies which have rendered valuable aid to their members at low cost; because it would of necessity, in the judgment of the

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[1] Pp. 68, 69, 72.

majority engaged in health care, interfere—in spite of protestations to the contrary—with the functional operations of hospitals, medical practice, and nursing service. This result would be inevitable if the provisions contained in the 84 pages of S. 5 were to become operative in determining the conditions, the quality, the quantity, and the personnel of the health service. As is evident in subsequent constructive proposals no opposition is voiced to the principle of having Government assume limited responsibility to promote public health, but rather opposition is pronounced against the unwarranted assumption of excessive social functions by the state.

The Bureau of Health and Hospitals of the Social Action Department N. C. W. C. in conjunction with the Catholic Hospital Association and the directors of Catholic Charities, after prolonged discussion of the many-sided problem have reached a consensus of opinion which may be formulated in the following statement:

STATEMENT OF THE CASE

The idea of personal individual responsibility for one's spiritual and material welfare is not only a basic doctrine of the church, but it is the cornerstone of American life. Many thoughtful people feel that we are losing our grip on this fundamental principle of personal responsibility, and submerging the dignity and personality of our citizens in a "welfare state." We do not ignore but rather emphasize the existence of a concomitant responsibility of society to create such conditions that the individual can readily achieve a state of physical and material well-being. It is the business of society through private and voluntary associations as well as through public agencies to see to it that the necessary means are available for the social welfare of the individual. It is not, however, the business of the state to assume all the functions of society, nor to relieve the individual of his own responsibility and deprive him of his freedom of choice.

It is most necessary we feel that these truths be recognized as the strength and fiber of the state. There is both an individual and a social responsibility. To ignore either phase of this working relationship is fatal to the commonweal. The question at issue, therefore, is not the promotion of better health care for the Nation—concerning which there is agreement—but rather a determination of the methods and policies which conform best to sound social principles. Health care should be made available to all people not only in terms of institutional facilities and trained personnel, but also in terms of reasonable cost to the public.

GOVERNMENT SUPPLEMENTS PRIVATE INITIATIVE

In accordance with sound social doctrine, we invoke the principle of subsidiarity. The workingman should have available adequate health service in times of sickness by either public or private insurance. We call attention to the alternative in the statement. We submit that a program of service by voluntary associations and private initiative backed by Government financial support is more in keeping with this sound social principle than a Federal compulsory health insurance system. The latter would impose a grave additional responsibility on the state, "which is now encumbered with all the burdens once borne by associations rendered extinct by it and in consequence submerged and overwhelmed by an infinity of affairs and duties."

The first and fundamental consideration in approaching the problem of the Nation's health is to determine definitely and clearly the shortages which now exist in terms of institutional facilities, personnel and technical services required to meet an adequate standard of health and physical well-being. The second consideration is to work out a program which will eliminate the existing shortages most effectively without violating sound social principles. Many surveys have demonstrated these shortages. Proceeding in accordance with this criterion, and on the responsibility of the Government report entitled "The Nation's Health" we enumerate the following shortages:

(1) *Shortage of hospital beds.*—The Ewing report of September 2, 1948, states that the country needs at the present time 900,000 more hospital beds for the care of acute sickness in general hospitals; a large increase is also needed to meet the shortage of beds in our chronic hospitals which serve the mentally afflicted, the tubercular, orthopedic, and similar categories of disabled and afflicted (see pp. 16–38 of report).

(2) *Shortage of physicians.*—The Ewing report states that whereas there are 190,000 physicians qualified to practice medicine at present, the number actually required to meet the needs of the American people within the immediate future is 254,000, provided the same ratio is maintained for the country as a whole

which now prevails in the top-level States. It must be remembered, furthermore, that only 5,600 graduates become available each year from our medical schools, whereas, 4,000 retire from practice, because of death, disability, or transfer to other activities (see pp. 16–38 of report).

(3) *Shortage of dentists.*—The Ewing report states that whereas we have at present 75,000 dentists, we need within the immediate future 95,000 in order to meet adequate health standards for the American people. The present ratio is approximately 1 dentist for every 1,850. Unless the number of dentists graduating annually from our dental colleges is increased, we shall have a worse shortage in the years to come (see pp. 17–42 of report).

(4) *Shortage of nursing services.*—The Ewing report states (p. 17) that our present supply of nurses is only 318,000 for the Nation, whereas 443,000 are needed in the immediate future. The American Nurses Association has estimated the current shortage of nurses at 42,000. Many more thousands will be needed by 1960 to staff the many new hospitals and local centers which must be built (see pp. 17–43 of report).

(5) *Shortage of community or public health centers.*—The Ewing report stated that the country needs within the immediate future 1,900 additional local health units. To staff these health units and to provide technical service for them as well as for hospitals and doctors and dentists, a very large increase in trained personnel is required.

Observations

(1) The proposed legislation known as S. 5 calls for universal compulsory Government health insurance for the income-earning groups in the United States of America. Except for a token increase to the appropriation under Public Law 725 and some provision for research and education, it depends upon the general economic law of supply and demand to eliminate the deficiencies. It should be pointed out that since hospitals and similar agencies are nonprofit institutions, they cannot respond to the law of supply and demand in the same fashion as commercial enterprises.

A direct attack on the above-mentioned shortages is to be preferred to the indirect and delayed improvement which the proposed legislation has adopted as its technique or policy. The primary attack made by S. 5 upon existing shortages, is that which is concerned with the lack of purchasing power for health care.

(2) The Bureau of Health and Hospitals of the Social Action Department, National Catholic Welfare Conference, and the Catholic Hospital Association have long recognized this problem of shortages and have repeatedly made proposals to remedy the deficiencies. We shall take occasion later in this statement to outline specific measures to improve the situation. We recognize that a system of prepayment of costs for hospitals, medical, dental, and nursing care is highly desirable and warrants our full approbation. We have endorsed the program of Blue Cross, Blue Shield, and other forms of voluntary insurance. We have advocated an extension of benefits as rapidly as conditions permit. We recognize that so far medical benefits are inadequate, but we do not admit that they cannot be improved and made comprehensive for the American people within a reasonable future, without resorting to compulsory Government health insurance.

(3) We wish to point out that in addition to the shortages of institutional facilities and technical services there are other factors which militate against the health and well-being of the Nation's citizens. We call attention particularly to the maldistribution of services and facilities between such States as New York and Mississippi or Arkansas. New York, for example, has 4.8 hospital beds for 1,000 of the population, whereas Mississippi and Arkansas have 1.9 and 1.8 respectively. The same disproportion exists in relation to medical, dental, and nursing service. No compulsory Government health-insurance program by itself can remedy this difficulty or maldistribution. Other means must be made use of to distribute our facilities and services more in accordance with need.

(4) It should not be overlooked furthermore that the compulsory Government health-insurance system makes only vague and general but no definite and concrete provisions for the medically indigent who constitute a large part of the problem of national well-being. No form of insurance predicated on a wage and income basis will take care of the many hundreds of thousands of widows, orphans, disabled, and dependent aged. Specific prouvisions should be made for this group who now constitute a heavy burden on public and private charity and frequently because of meager resources receive inadequate care.

CONSTRUCTIVE PROGRAM

In order that the moral and social principles which underlie the consideration of a national health program may be safeguarded, and in order that the legitimate autonomy of hospitals and professional groups may be fully preserved, the Bureau of Health and Hospitals of the Social Action Department, NCWC, in conference with the Catholic Hospital Association and the directors of Catholic charities, submit the following constructive program as an illustration of a sound public policy to promote the health and well-being of the people of the United States.

(1) Division of Health

We recommend that within the Federal Security Administration there be created a Division of Health which will have authority and responsibility over the health-service functions and activities here proposed. For the direction of this new Division of Health a Federal health council shall be established which will determine the policies and approve the fundamental rules of administration in respect to the health appropriation from tax funds. This Federal health council shall be composed of nine members, three of whom are to be physicians, three hospital administrators (one a nurse), and three representatives of the public. Candidates for membership on the council should be recommended by their respective groups, passed on by the Senate, and appointed to the council by the President of the United States.

We recommend that there be established similar health councils at State and local levels, the composition and function of which will follow the pattern of the Federal health council.

We recommend likewise that the Federal Security Administrator be the executive officer of the Government in the administration of health, with a qualified physician as his assistant in charge of the Division of Health.

(2) Hospitals

We recommend that the Federal Government—

(*A*) Increase its grant for hospital construction under Public Law 725 from the present amount of $75,000,000 per year to a sum of $200,000,000 until such time as the need is satisfied. An appropriation of $200,000,000 matched by beneficiaries on a sliding scale in the ratio of one-half, two-fifths, one-third, corresponding to the priorities of need for construction indicated as (A), (B), (C), respectively, will provide each year for the construction of 40,000 to 50,000 new hospital beds. The total fund available would be approximately $500,000,000 from all sources and at an average cost of $12,000 per bed the above figure of 40,000 to 50,000 new beds would seem to be approximately correct.

(*B*) Grant a subsidy to help defray operating costs in scattered and rural areas by means of a sliding scale in accordance with the resources of the area. The total annual budget for operation need not exceed the sum of $25,000,000.

(3) Physicians

We recommend that the Federal Government—

(*A*) Provide assistance to medical colleges, by paying up to 50 percent of the salaries of the teaching staff, with a ceiling of $10,000 per person per year, subject to approval of the Federal council. We suggest a sum of $10,000,000.

(*B*) Arrange to provide a grant-in-aid program for the construction of needed facilities and equipment for medical schools to care for the additional students referred to in (*C*) below; the pattern for this grant-in-aid program is already established in Public Law 725. For this purpose we suggest an appropriation of $50,000,000.

(*C*) Establish a system of loan scholarships to medical students at $1,000 per year, repayable within 10 years after graduation; suggested appropriation $10,000,000. An appropriation of $10,000,000 would provide scholarships for 10,000 students at the rate of $1,000 annually per student. Since this would be a revolving fund, it would in course of years operate itself. A condition of acceptance of scholarships would be the promise to devote 5 years with a Federal commission under the Division of Health to render service in areas of need.

(*D*) Grant Federal commission with a value of $2,500 to physicians (part-time service) under the proposed Division of Health in order to provide resident service in least-favored areas or in rural areas of scattered population. The number of commissions might well be graduated in accordance with the average ratio of doctors now practicing in the 12 most-favored States. The approximate total budget need not exceed the sum of $5,000,000.

(*E*) An appropriation of $25,000,000 for medical research could be distributed among the medical colleges in accordance with their particular facilities and under the rules and regulations adopted by the Federal council in the Division of Health.

(*4*) *Dentists*

We suggest the Federal Government adopt the same program for dentists as for physicians. The total estimated appropriation need not exceed the sum of $15,000,000 per year.

(*5*) *Nurses*

We recommend that the Federal Government—

(*A*) Provide assistance for schools of nursing in the amount of $250 per year for each student to defray part of the cost of tuition and maintenance, with an additional $250 per year to each student, to meet personal living costs. Under this profram the training periods could well be modified. Students participating in this program would be obliged to pledge their services for 3 years under a council assignment as outlined in (*B*) below. We suggest the sum of $25,000,000 per year.

(*B*) Provide commissions with financial support under the Federal Division of Health to nurses in rural areas and less-favored States. These scholarship nurses would be attached to community health centers or assigned to voluntary or Government hospitals. We suggest that the total appropriation for this purpose be the sum of approximately $10,000,000 per year. Obligatory service shall not exceed 3 years.

(*6*) *Additional professional personnel*

We recommend that the Federal Government adopt a similar program for the preparation of additional professional personnel, including medical social workers, nurse anesthetists, technicians, dietitians, etc. For this purpose we suggest an annual appropriation of $12,500,000.

(*7*) *Practical nurses.*

We recommend that the Federal Government adopt a program suitable for the training of practical nurses. We suggest an annual appropriation of $12,500,000.

(*8*) *Community health centers*

We recommend that the Federal Government assist in the construction of community health centers throughout the country, to provide, under the responsibility of local health councils, diagnostic and therapeutic services and emergency care. These health centers are to be located in rural areas and/or areas of special need. We suggest an annual appropriation of $25,000,000. The pattern is already established in Public Law 725.

(*9*) *Financing of projects*

We suggest that the Congress enact legislation by means of separate bills for each specific project mentioned above, and appropriate the money needed respectively from the general funds. The program of financing should follow a logical and chronological development to assure that adequate personnel and facilities will be available in order to render the service advocated and promised. This procedure would make allowance for the economic conditions prevailing at a given time and would be more equitable with the money coming out of regular income taxes than if the cost of construction and subsidies were to be assessed against an insurance trust fund created by the contributions of people in the low-income brackets.

The total budget for the above purposes would be approximately $450,000,000. A further detailed study of the specific needs in each category may modify some of the figures mentioned, but the total would be less than $500,000,000. This sum constitutes a little more than 1 percent of the total present Federal budget and would necessitate merely a proportionate increase in the existing tax rates.

(*10*) *Prepayment of costs of sickness*

(*A*) At the present time there are more than 33,000,000 people in the United States covered by hospital insurance in the Blus Cross and a rapidly growing number in the Blue Shield for medical or surgical benefits. There are approximately 52,000,000 if we include all types of hospital insurance. Another large group of Federal employees could also be included if prohibitions were removed. In order to stimulate enrollment in these voluntary insurance systems and to increase the benefits under Blue Shield so as to include full-scale medical and surgical care given in approved hospitals, we suggest that the Congress amend the income-tax law so as to permit a deduction of premiums up to $75 for health insurance from the net income tax of all individuals in the lower-income brackets, i. e., up to $5,000.

By reason of the deductions allowed for voluntary insurance up to the sum of $75 per individual within the lower income brackets (namely less than $5,000), there would be a total deduction from the income tax budget of approximately 1½ billion dolalrs. This figure is based on the assumption that there are 60,000,000 employed and that 18,000,000 earn more than $5,000 per year and 42,000,000 are earning less than $5,000.

Amongst the 42,000,000 earning less than $5,000 we assume that half do not pay any income taxes. In consequence there would be 21,000,000 gainfully employed persons who would be entitled to a $75 deduction from their income taxes. In this order the total loss to the Government would be 1½ billion dollars.

If we add the reduced income tax receipts of $1½ billion to the $650,000,000 additional appropriation for health services, we have a little more than a sum of $2,000,000,000 to be provided by the Government by way of new taxation * * * cf. page 17 for addition to budget.

By contrast the imposed compulsory insurance law would impose a new burden of approximately $6,000,000,000 tax on wage earners.

(*b*) We recommend that the Congress extend the benefits under the social security law so as to include disability due to sickness in the same category as unemployment.

While the medical benefits that provide two-thirds of the workers income for 18 to 26 weeks may be sufficient to tide them over the ordinary illness, it is apparent that any program that does not take care of catastrophic illness will fail to meet the needs of the ordinary wage earner. From the very beginning of the social security program the directors of Catholic Charities have held that social insurance should be the foundation of a health program. They have not thought about social security benefits as a means of providing every individual with complete protection against the hazards of life. They have assumed that the worker could not depend entirely on social insurance benefits, but that he was capable of thinking and doing some planning on his own.

(*c*) We recommend that in addition to existing health services rendered by the Federal, State and local governments that the Congress authorize and appropriate the sum of $200,000,000 to assist the States in providing health care for the group in the lowest-income brackets and for those without any income, technically classed as medically indigent. The Federal funds should be apportioned among the States according to a sliding scale in accordance with the respective needs of each area and made available for the purchase of Blue Cross, Blue Shield, and other forms of voluntary health care. It is recommended that each State health agency, subject to the approval of the Federal Health Council, establish a program to purchase service on a basis of payment of costs for hospital service and on a fixed-fee basis for medical and surgical service. For the purpose of this section the term "medically indigent" shall include all persons living in any State if certified as such by a State approved charitable agency public or private. No further means test will be applied in any form by the State health agency.

(*d*) We recommend furthermore, in order to meet the widely varying problems of the respective States and conform to the existing facilities of each area of the country, that there be authorized and appropriated by the Congress the sum of $10,000,000 to assist the individual States to make available at their own option a system of prepayment of costs of hospital, medical, and surgical care for their respective areas but under the following conditions:

1. The Federal grant-in-aid shall be distributed on a sliding scale and on a State matching basis in accordance with the pattern established in Public Law 725;
2. The individual States desiring to avail themselves of the Federal grant for this purpose shall establish a State health insurance agency with a council appointed by the governor to determine the policies and approve the regulations as set forth previously for the composition of the Federal council;
3. The State health agency shall be authorized to purchase health protection through Blue Cross, Blue Shield, or other voluntary agencies or to establish its own health insurance system if it is found necessary to make readily available adequate health protection to its population. The coverage provided should include hospital service and also medical and surgical care within the hospital;

4. The insurance premiums should be graduated according to the coverage described in the policy, adequate to establish necessary reserves and sufficient to insure the benefits promised as well as to provide security of the operation as a self-sustaining program according to actuarial principles;

5. The insurance plan should provide a fixed fee schedule of payments for medical and surgical care within a hospital and payments to the hospital by contract for the cost of service on a per diem basis.

6. The State health insurance plan should be made available at county or local health agencies to any resident of the State at his own option and on payment of the established premium. Thus under localized sponsorship and administration adequate health care by prepayment of cost on an insurance basis could be obtained by all residents of a State. At the same time there would be developed a strong incentive to utilize the voluntary systems and extend this coverage.

CONCLUSION

We call attention to the fact that compulsory government insurance programs would by necessity destroy existing Blue Cross and Blue Shield and many mutual welfare systems as well as all fraternal and commercial health insurance systems. The proposed legislation of S. 5 presents a highly complicated system of directing, regulating and controlling health services which in the judgment of hospital authorities and medical men would be practically unmanageable and which would so increase demands on existing facilities and personnel that the very weight of the premature demand would necessarily cause a deterioration of the quality of the services rendered.

It is our fervent hope and purpose by means of the system proposed in this statment to assure each citizen and the members of his family that they will enjoy under God's Providence the best possible medical care.

Bureau of Health and Hospitals
The National Catholic Welfare Conference
Rev. D. A. McGowan, *Director*.
The National Conference of Catholic Charities
Rt. Rev. Msgr. John O'Grady, *Secretary*
The Catholic Hospital Association
Rt. Rev. Msgr. George Lewis Smith, *President*.

March 25, 1949.

Monsignor Smith. As the Most Rev. Karl J. Alter, bishop of Toledo and chairman of the administrative board of the Catholic Hospital Association, says in his foreword to our statement:

> There is no controversy or disagreement concerning the advisability or advantage of a prepayment plan to meet the cost of medical care. Acceptance of such plans is practically unanimous. The division of opinion concerns the question whether there should be an exclusive state monopoly or whether there should be a cooperating partnership between the Government and voluntary health agencies.

There is very little difference of opinion concerning the necessity of promoting the health of the people of our country by preventive effort and by providing adequate care during periods of sickness and disability. There is, however, a decided difference of opinion regarding the methods that should be followed in securing this objective.

With your permission I will quote three paragraphs from page 9 of our statement.

> The idea of personal individual responsibility for one's spiritual and material welfare is not only a basic doctrine of the church, but it is the cornerstone of American life. Many thoughtful people feel that we are losing our grip on this fundamental principle of personal responsibility, and submerging the dignity and personality of our citizens in a "welfare state." We do not ignore but rather emphasize the existence of a concomitant responsibility of society to create such conditions that the individual can readily achieve a state of physical and material well-being. It is the business of society through private and voluntary associations as well as through public agencies to see to it that the necessary means are available for the social welfare of the individual. It is not, however,

> the business of the state to assume all the functions of society, nor to relieve the individual of his own responsibility and deprive him of his freedom of choice.
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> It is most necessary, we feel, that these truths be recognized as the strength and fiber of the state. There is both an individual and a social responsibility. To ignore either phase of this working relationship is fatal to the common weal. The question at issue is not the promotion of better health care for the Nation—concerning which there is agreement—but rather a determination of the methods and policies which conform best to sound social principles. Health care should be made available to all the people not only in terms of institutional facilities and trained personnel, but also in terms of reasonable cost to the public.
>
> In accordance with sound social doctrine, we invoke the principle of subsidiarity. The workingman should have available adequate health service in times of sickness by either public or private insurance. We call attention to the alternative in the statement. We submit that a program of service by voluntary associations and private initiative backed by governmental financial support is more in keeping with this sound social principle than a Federal compulsory health-insurance system.

Although there may be some difference in the exact estimates, we all recognize that there are serious existing shortages of hospital beds, of physicians, of surgeons, of dentists, of nurses, of other technical and professional personnel and of community health centers. We testified in favor of Senate bill 614 to extend and expand the Hill-Burton Hospital Construction Act (Public Law 725) at the hearings before this committee on May 9, 1949, but at that time I called attention to the fact that providing funds for the erection of hospital buildings in needed areas is doing only part of the job, for a hospital building must be adequately equipped, staffed, and maintained before it really functions as a hospital.

We realize that some people are not getting all the hospital and medical care they need for themselves and their families, and that there is urgent need to extend the great hospital service and medical care we have in America to those who are not getting it now, but we are opposed to a totalitarian program to take care of everybody, regardless of need, from birth to death according to Federal specifications. We are not necessarily opposed to a compulsory Federal tax, even if it be a specific health tax, to subsidize the cost of part of the hospital and health care not only for the totally indigent, but of the low-income groups which may become medically indigent through a catastrophic illness or disability, as well. All of us want to remedy the existing shortages and improve the availability of our health and hospital facilities, but we are definitely opposed to the compulsory health-insurance provisions of Senate bill 1679. An adequate national health program and compulsory Federal health insurance are not necessarily synonymous.

We have submitted constructive proposals in our statement for the Federal Government to assist in the alleviation of these shortages of facilities and personnel, the encouragement of enrollment in voluntary prepayment plans for those earning less than $5,000 a year by the incentive of an income-tax deduction, and Federal assistance to the States on a sliding scale to provide health care for the group in the lowest income brackets and those without any income, technically classed as medically indigent.

We recognize that the Government must asume the leadership in preventative medicine and in the care of the mentally ill, the tubercular, and chronic cases, but not to assume the responsibility of taking care of those who want to and can take care of themselves.

We believe that the efforts of the Federal Government should be directed to assisting in the solution of the problems of the shortages of institutional facilities; the subsidizing of the education and training of doctors, nurses, and technical personnel who will agree to serve for a limited time in areas of greatest need; to utilize voluntary prepayment plans as far as possible; and to provide grants in aid to the States for the care not only of the totally indigent but for the medically indigent as well. We believe that the 33,000,000 American people now covered by Blue Cross voluntary hospital prepayment plans and the almost 20,000,000 more who have commercial insurance or other benefits to help with their hospital bills, as well as the vast number of others who have sufficient resources of their own and who can take care of themselves and their families through voluntary effort want to continue to do so. We want to maintain the intimate personal relationship between physician and patient and the autonomy of our hospitals.

It is our fervent hope that through voluntary effort and private initiative, aided by governmental financial support, we can develop a national health program which will assure to each citizen and the members of his family as adequate medical, health, and hospital care as can be provided under the circumstances and we pledge our best efforts to cooperate in achieving this objective.

Senator MURRAY. Thank you very much for your statement, Father.

Monsignor SMITH. I would like to mention that Father Donald McGowan will testify on behalf of the Bureau of Health and Hospitals and supplement our testimony.

Senator MURRAY. Father Donald McGowan from the National Catholic Welfare Conference?

Monsignor SMITH. Yes.

Senator MURRAY. Of course, we are all working to the same end, to try to solve this tremendous and serious problem that confronts our country. I have had many meetings with representatives of the Catholic Hospital Association and I have always found them very helpful in trying to find a solution to our problems. I am very glad to have had your testimony here today.

There is, of course, a division of opinion amongst Catholics with reference to those programs. I get letters from around the country. I see articles printed in Catholic papers in which they commend our program, the national health program, and others criticize it. I have a copy here of the Pittsburgh Catholic and it has this statement in it.

Monsignor SMITH. I think that Father McGowan as a direct representative of the National Catholic Welfare Conference will perhaps go further than I can on that.

Senator DONNELL. Mr. Chairman, may I interrupt? There is a quorum call. I have no doubt you and I both ought to be there. I wonder if Monsignor would be kind enough to wait for us. I would like to ask him a few questions.

Senator MURRAY. All right, Monsignor, if you will just wait until we get back.

(After recess:)

Senator MURRAY. You may question.

Senator DONNELL. Monsignor, may I ask you right at the outset, do you happen to have with you a list of hospitals that are in your association?

Monsignor Smith. No.

Senator Donnell. The reason I asked you is this: I referred to a hospital back in my own home town, back in Missouri, and I called it St. Joseph's Hospital. I am inclined to think I was wrong in the name of it. Do you happen to know?

Monsignor Smith. No. We have a directory here from Father McGowan's office. We can get it for you.

Senator Donnell. I would like to have it put in at this point. I do not care to have it changed, but I would like to have the correct name.

Monsignor Smith. Mr. Reed of NCWC is here.

Senator Donnell. It is Maryville, Mo., and I would like to have the correct name of it for the record.[1]

Monsignor Smith. Maryville, Mo. I do not recall, sir.

Senator Donnell. Well, it is not strange. You have approximately 800 hospitals in your organization.

Now, Monsignor, I would like to ask you just a few question along the line of your own experience. Now, you are president of the Catholic Hospital Association of the United States and Canada. Are you from South Carolina?

Monsignor Smith. Yes, sir.

Senator Donnell. I wanted you to tell us, if you will for the record, something of your personal knowledge and experience of the hospital situation. I do not mean as set forth in your statement; but something of your own personal background to go into the record at this point.

Monsignor Smith. Well, I am past president of the South Carolina State Hospital Association, and I am more familiar perhaps with the conditions in the southeastern area than in some other sections of the country, although I have had to travel about the United States and Canada in the fulfillment of my duties as president of the Catholic Hospital Association.

Now, I feel that the building of hospitals, even with the aid of Public Law 725, is meeting only part of the problem because you cannot have a good hospital just with the physical structure. There has to be some incentive to get competent young men trained in medicine and surgery to stay in that area to serve, use that hospital as their workshop; you have the same problem with nurses and with other technical and professional personnel, so that there is a danger in my mind that if you build hospital beds and do not keep pace with the development of personnel and doctors to staff it, that you are going to have a lopsided result; you are going to have hospitals that cannot give the kind of hospital care that should be given; so you have to have a coordinated development of hospital construction and the stimulation, the education, the training of personnel and staff, and all that goes with the making of a good hospital.

Senator Donnell. You have been a student of the hospital situation in this country and Canada for a good many years, I assume.

Monsignor Smith. Yes. I have served as chairman of the board of the Catholic Hospital Association since 1938 or 1939.

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[1] The name of the hospital at Maryville, Mo., is the St. Francis Hospital.

Senator DONNELL. Would you be able to tell us, Monsignor, just roughly, how many hospitals you have visited from time to time? It is quite a large number, is it not?

Monsignor SMITH. I cannot tell you, but quite a considerable number.

Senator DONNELL. Quite a considerable number. So that you are not only officially the head of this organization, but you have actually personally studied it?

Monsignor SMITH. Yes.

Senator DONNELL. And you know something of the problems of the hospitals and are, therefore, undoubtedly acquainted with many of these questions that arise under compulsory health insurance.

Monsignor, Senator Murray referred to some differences of opinion and read from the Pittsburgh paper. There are many—I do not know how widespread the opinion contrary to your own is among Catholics; but there are certainly others that take the same view that you take, I take it. Are you acquainted with Father Schwitalla in St. Louis?

Monsignor SMITH. Very well; he is my predecessor. I spent a few days with him a fortnight ago.

Senator DONNELL. Father Schwitalla is one of the prominent monsignors in the United States, and he has testified before our committee, and I might say his views are in accord with your suggestion. Is that not your understanding?

Monsignor SMITH. Yes. As a matter of fact, we had quite a long discussion within the last fortnight in St. Louis about it.

Senator DONNELL. You mentioned S. 1679. I wonder if you had occasion to study what is called the Taft bill, S. 1581.

Monsignor SMITH. I have read the bills, but we are not in a position at this hearing today to go on record concerning specific legislation for this reason—that in matters of public policy, legislation, and public relations have to be passed upon by our administrative board which meets in St. Louis the week of June 13, so that I am not in a position to make any commitment one way or the other as to specific legislation.

Senator DONNELL. May I ask you, Monsignor, if that meeting to be held in St. Louis in June should express itself upon any of these bills, S. 1581, S. 1679, or Senator Hill's bill, S. 1106, with the approval of the chairman of our committee, would you be kind enough to furnish us with copies of the resolutions or other official action that might be taken so that they might be either filed with the committee or incorporated in the hearings?

Monsignor SMITH. We should be glad to do that.

Senator DONNELL. Might I have leave to do that, Mr. Chairman?

Senator MURRAY. Yes. I will see that they are furnished with the record.

Senator DONNELL. Thank you.

I notice that you do express yourself in this statement as being in favor of the view that the efforts of the Federal Government should be directed to various points which you mentioned, included among which is the provision of—

> grants-in-aid to the States for the care of not only the totally indigent but for the medically indigent as well.

Monsignor SMITH. Yes.

Senator DONNELL. Are you familiar with the fact that S. 1581 does contain a series of grants-in-aid to the States?

Monsignor SMITH. Yes.

Senator DONNELL. Well, I notice also that you say on page 4:

> We are opposed to a totalitarian program to take care of everybody, regardless of need, from birth to death according to Federal specifications.

Are you familiar, Monsignor, with the fact that S. 1581 takes into consideration the need and is based upon the proposition of need as distinguished from taking care of everyone?

Monsignor SMITH. Yes.

Senator DONNELL. So that I take it in those two respects, even though you are not prepared now officially to present the views of your organization, your own personal views would be favorable to those principles expressed at any rate in S. 1581?

Monsignor SMITH. Our principles are expressed in this statement which we have filed as part of this record.

Senator DONNELL. Well, you are in favor of those two principles to which I have referred as being embodied in S. 1581?

Monsignor SMITH. So far they are in accordance with the expression of our official statement.

Senator DONNELL. Yes. Monsignor, I wonder if I might take a look for just a moment at the joint statement that you have.

Monsignor SMITH. It was attached to the statement.

Senator DONNELL. Yes, I see. Very well.

Well, Mr. Chairman, I will not take any further time. I thank the monsignor for his testimony.

Senator MURRAY. Father McGowan.

Senator DONNELL. Mr. Chairman, was the booklet entitled "A Voluntary Approach to a National Health Program" to be incorporated in the record?

Monsignor SMITH. It was.

Senator DONNELL. I think it would be well to insert it.

Senator MURRAY. You asked for it.

Monsignor SMITH. I asked for it.

Senator DONNELL. Thank you.

STATEMENT OF REV. DONALD A. McGOWAN, DIRECTOR OF THE BUREAU OF HEALTH AND HOSPITALS, NATIONAL CATHOLIC WELFARE CONFERENCE, WASHINGTON, D. C.

Senator MURRAY. You may proceed, Father McGowan.

Reverend McGOWAN. Mr. Chairman and members of the committee, first of all, I want to thank you, Senator Murray and Senator Taft and Senator Donnell and the other members of the committee for the privilege of appearing before you.

I am the Reverend Donald A. McGowan, director of the bureau of health and hospitals of the National Catholic Welfare Conference.

Few things in life are more precious to a person than his health. Because this is true, governments have always shown an honest interest in the physical well-being of their members.

In our own country, this solicitude has become clearly and narrowly focused on a so-called national health program, or to use the latest term, "A National Health Insurance and Public Health Act." The fury and debate concerning such a program have swung from one extreme to the other. Unfortunately, there has been an unwholesome amount of name calling, which at best is unproductive and at worst merely camouflage for prejudices.

As usual, the true solution to a problem of such social significance is to be found somewhere between the antipodes of heated opinion.

Besieged, as we were, from all sides for a statement of policy in this field of national health, three Catholic organizations, the bureau of health and hospitals of the National Catholic Welfare Conference, the National Conference of Catholic Charities, and the Catholic Hospital Association, made public our views.

On April 18 of this year, 1949, a news release sponsored by the three groups made clear our stand on compulsory health insurance in a statement called A Voluntary Approach to a National Health Program.

Senator DONNELL. Pardon me, Mr. Chairman. That is the pamphlet that was filed by the monsignor.

Reverend MCGOWAN. Yes, Senator Donnell. The statement was written after long study and deliberation. It was inspired by a strong desire to achieve the goal of even better health for the healthiest Nation in the world. Its prime purpose is constructive rather than critical. It does not, however, presume to take on the character of a health bill. The complicated business of writing legislation must remain the prerogative of our duly elected representatives in the Senate and the House. Our efforts have been directed toward the achievement of a common objective. Unfortunately there is a disagreement among men of good will in this entire matter of health care.

That the interests of the Catholic Church are inseparably bound up to health care is made abundantly clear by 2,000 years of sacrifice and labor in this field. That tradition of accomplishment cannot be ignored. It is in complete harmony with the proud history of health care in our own Nation.

We are grateful that the present controversy is one between men of good will. This being true, we have proposed a series of suggestions for the solution of an admitted problem—namely, more adequate health care for the American people.

We have approached this problem with realism and sympathy for those burdened by the necessary costs of illness.

Perhaps this quotation from page 16 of our statement will explain our method of attack, and I quote:

> We suggest that the Congress enact legislation by means of separate bills for each specific project mentioned above, and appropriate the money needed respectively from the general funds. The program of financing should follow a logical and chronological development to assure that adequate personnel and facilities will be available in order to render the service advocated and promised. This procedure would make allowance for the economic conditions prevailing at a given time and would be more equitable with the money coming out of regular income taxes, than if the cost of construction and subsidies were to be assessed against an insurance trust fund created by the contributions of people in the low-income brackets.

That a new job must be done is clearly evident. The method of advance is, we grant, a problem. Our statement, however, represents the sound, solid conviction of a large group in the health field. I repeat: It is not a bill, but it will furnish, we hope, guideposts in our march toward greater effectiveness and efficiency in the preventive and curative practice of the art of healing.

And in closing I wish to thank the chairman, Senator Murray, for allowing Monsignor Smith to incorporate the statement in the record.

Senator MURRAY. I thank you, Father. The teachings of the Catholic Church are not unalterably opposed to a program of compulsory health insurance?

Reverend McGOWAN. Not at all, Senator Murray.

Senator MURRAY. And among the members of the church there is a division of opinion on that. Some people feel that the only way to cure this situation in this country is by a national health program, and others feel that it should be handled in some other manner.

Reverend McGOWAN. That is correct, Senator Murray. However, at this point I would like to emphasize the fact that after a great deal of study and deliberation on the part of the three groups represented in our statement the administrative board of bishops of the country on April the 26th voted unanimously to support the statement and made it the official stand of the administrative board of bishops of the United States.

Senator MURRAY. Back in 1919 the bishops program of social reconstruction recommended that—and I quote:

> until the level of legal minimum wages is reached, the worker stands in need of the device of insurance. The State should make comprehensive provision of insurance against illness, invalidity, unemployment, and old age.

Commenting upon this statement of the bishops, Cardinal Edward Mooney, then Archbishop Edward Mooney, chairman of the administrative board of the National Catholic Welfare Conference, said in 1939:

> The social insurance provided in the Social Security Act is by no means perfect. to say nothing of other defects, it fails to provide for workers insurance against sickness.

In 1945 Bishop Francis J. Haas, of Grand Rapids, Mich., speaking in Chicago, said:

> Now and without delay Congress should broaden the Social Security Act to include health insurance.

This is reprinted from October 1947, an issue of the American Catholic Sociological Review, "Public Health Insurance in the United States."

Senator DONNELL. Pardon me, Senator. I wanted to ask you again the basis upon which that statement was made.

Senator MURRAY. It was made in April 1919 and then in 1939, and reprinted in October 1947, in the issue of the American Catholic Sociological Review.

Senator DONNELL. It was not reissued, however, by the maker of the statement in 1947?

Senator MURRAY. No. It was reprinted.

Senator DONNELL. That is just a copy of it; that is, just a copy of it was reprinted?

Senator MURRAY. Reprinted at that time.

Senator DONNELL. The point that I was getting at, the man who made the statement did not reassert that same opinion in 1947?

Senator MURRAY. No. It does not say so.

Reverend McGowan. Senator Murray, that does not represent a conflict of basic ideas. It represents a difference of interpretation of a problem, and I am very happy you brought that up, because it gives us a chance to reemphasize what we have always believed: That health of itself is only one of the problems of the social happiness of any person in this country, and if you will continue to read the context of those statements you will find that Cardinal Mooney indicated that any compulsory Government health insurance would be a temporary measure desirable only until the over-all welfare of the citizen made it possible for him to take care of his own needs.

Senator Murray. I have another statement here taken from the October 1947 issue of the American Catholic Sociological Review which reads as follows:

> Christian social teachings not only gives the States the right to enact a national health insurance law but also imposes a duty under certain conditions to set up a universal health insurance program. What are these conditions? And following Pope Leo XIII's guiding principle for state intervention, it may be said that public health insurance becomes a necessity (1) when there is a real need among the Nation's families for good medical care; (2) when the common good or the physical welfare of his people is jeopardized by their lack of medical care; (3) when existing agencies and organizations are unable to cope with the problem; (4) when government action is the only way of protecting these families against the risk of sickness and providing for the common good.

There are other statements along the same line.

Reverend McGowan. I would like, if I may, Senator Murray, to speak in respect to that statement you have just made.

Senator Murray. Yes, sir.

Reverend McGowan. We agree absolutely with the principles outlined in that statement. However, we do not feel that it has been demonstrated that State intervention is the only way of taking care of this problem. To get back to your own statement of a few minutes ago, Senator Murray, you said there is nothing in the doctrine of the Catholic Church that is opposed to compulsory health insurance, and that is absolutely correct. However, the doctrine of the church is sound social doctrine which may be simply stated, as Monsignor Smith has already stated it, thusly: No government should do for its people what the people can do for themselves.

Senator Murray. That is true, all except——

Reverend McGowan. If the time comes when we can prove that Government intervention on a compulsory universal basis is the only way to take care of our people—and you will note that in that statement that you read there it was very strong—if that is the only way, then we would be bound in conscience to support it. It remains, however, to be demonstrated that that is the only way, and we feel that, adopting the American form of government and in harmony with the efforts that we have made through the years on a voluntary basis, that further exploration of the voluntary method will solve our problem, with a certain amount of Government assistance.

It is quite obvious—and I have known this for years, and to satisfy Senator Donnell before he asks me, I was the assistant superintendent and the actual superintendent of a 300-bed hospital for 10 years and the past president of the New England Hospital Association and the past president of the Massachusetts Hospital Association and a member of the board of directors of the Massachusetts Blue Cross plan for several years before I came down here to Washington, and also a member of the advisory council for the implementation of Public Law 725 in Massachusetts, so I feel somewhat qualified to speak in respect to the questions that arise.

Senator MURRAY. I am sorry that we have such a conflict in this country, but there are a great many people in the United States who feel that the only way to cure this situation is by a universal system such as is proposed in this bill which we have been sponsoring. I know that at the time that we first introduced that legislation there seemed no other avenue of escape. When we introduced the bill we were immediately attacked and criticized for having filed it and have been abused ever since by some people, although there has been a general dawning of opinion in the country, I think, that there must be some way to meet the problem. But it was only as a result of the filing of this legislation and the agitation resulting that there was any effort whatever made. There never would have been anything done had it not been for the filing of this legislation.

Reverend MCGOWAN. I think you are absolutely correct, Senator.

Senator MURRAY. I had the support and backing of members of the Catholic clergy at the highest positions. Father Haas was down here several times and the priests in the National Catholic Welfare organizations all around the country, and I cannot see anything that is fundamentally wrong with the national system. I just cannot see it.

Reverend MCGOWAN. There is nothing fundamentally wrong with the national system, Senator Murray, if it can be demonstrated that that is the only way of caring for this problem.

Senator MURRAY. Well, I think that is demonstrated in the minds of the majority of the American people according to the poll that has been taken, and, of course, I do not know how else you are going to demonstrate it. It has to be by the judgment of the people of this country, and that is what they want.

Reverend MCGOWAN. Well, 52,000,000 people is not an insignificant percentage of the population.

Senator MURRAY. Fifty-two million?

Reverend MCGOWAN. Who are already covered by some sort of health insurance, voluntary or otherwise.

Senator MURRAY. Well, they are already covered by some sort of a program, but I think if we were to analyze that 52,000,000 people we would find that some of them are very poorly provided with protection against a serious illness, because the Government programs are not comprehensive. They do not cover all the risks.

Reverend MCGOWAN. And neither does the administration bill, if I may say so, Senator.

Senator MURRAY. Oh, yes, it does. The administration bill covers—of course, you mean with reference to the commitment. Of course, it is not possible for us because we have not got enough doctors to commence with, and we have not enough hospitals, and our program is to educate more doctors, provide more hospital personnel, and expand the hospital system, and in that way we will eventually have a set-up that will provide adequate and complete care for the American people, it seems to me.

Reverend MCGOWAN. I am very happy that you mentioned that in chronological order, and that is why I took the time to quote from our statement, that we do not feel that any omnibus bill such as this which is before me should be passed. We do not feel that that is the proper way to legislate for a thing as important as health care.

Senator MURRAY. Well, we are conducting this hearing, and we are considering all of these things at the same time, but it is not necessary for us to wait and enact an omnibus bill that will contain every one of these problems. We could stop in a few weeks and begin writing legislation to cover the medical education features of it, the research, and the expansion of hospitals, and so forth.

Reverend MCGOWAN. With that approach, Senator Murray, I want to go on record as saying that I agree absolutely.

Senator MURRAY. Well, when we come along to this proposition of taking care of the hospitals, as Monsignor Smith said a little while ago, to have the hospital and to have the doctors and to have the personnel is not everything. You have got to be able to support it, and I think the only way you can fully and adequately support the hospitals of the country is through a national system such as we propose here and, of course, as you say, we cannot put it into complete and perfect operation until we have enough doctors to do it with, enough dentists to do it with, but we propose to expand it as we go along.

Reverend MCGOWAN. That is very well spelled out in the administration bill. There was a passage, Senator Murray, from an article concerning which I had the honor to appear with yourself and Senator Taft on a debate on Truman's medical health bill which appeared in the Evening Bulletin in Philadelphia Thursday, May 19, 1949. In the article which I wrote I inserted a little homely New England common sense and said that I did not feel that because a man had a simple fractured wrist that it was necessary to put on a complete body cast, and I think that is what we are doing. I think that because the house needs a room papered or a porch fixed is no justification for tearing down the house and starting all over again, and we certainly agree—every man of good will—and I emphasize that in my statement, that this is a disagreement between men of good will—we all agree that there are deficiencies. We simply disagree on the method of approach to the solution of the problem, and I for one from my experience am a little bit frightened by the controls that may possibly come about through a compulsory universal health act.

Senator MURRAY. I have been appearing in meetings in connection with this proposed legislation now for a good many years, and I do not feel a bit alarmed by the administration of such an act. I have been in contact with the administrators here of social security, and I cannot bring myself to feel that there is any real danger in this kind of a program, especially with the safeguards that we set up here with reference to how it should be administered and centralized administrations, and so forth, which would be a matter that could be administered without any difficulty.

Reverend MCGOWAN. I want to repeat for the record that I have the highest regard for the gentlemen who have interested themselves in any phase of this health legislation, and I do not want to appear captious at all, but I would like to point out that on page 117 of the bill under section 717, "Provisions common to all agreements" the paragraph (c) says, and I quote:

> No agreement made under this part shall confer upon any individual or other person or any group or other organization, the right of furnishing or providing personal health services as benefits, to the exclusion in whole and in part of other individuals from persons, groups, or organizations qualified to furnish or provide such services.

As a hospital man and from a little bit of experience, I think that perhaps if that particular paragraph were implemented to its fullest meaning that it might break down the staff organization that we now have in our hospitals, because we say here that we cannot exclude anyone who was participating in the program, and it would be my understanding "that any individual" might mean a participant at any level, a doctor perhaps or a nurse or a subscriber or a beneficiary.

Senator MURRAY. How would you suggest that that provision read? What do you offer to substitute?

Reverend McGOWAN. Well, Senator Murray, as we have said so often, we are not here to write legislation. That is not our job. But I feel that the autonomous character of the board of trustees of any nonprofit hospital must be protected, and I hasten to add that that is also in your bill.

Senator MURRAY. What is that?

Reverend McGOWAN. That is also in your bill, those provisions.

Senator MURRAY. The provisions are in there to safeguard the system so that it will not permit monopoly to develop or control the system by any group. If there is any language that is essential to make it more clear and effective, I would be glad to have it.

Reverend McGOWAN. Might I point out for the sake of the record something else that is not necessarily an inconsistency but might possibly be misleading from the point of view of the public? We are told in the press and on the radio that the administration bill is an all-inclusive program. You and I and those who sponsored it know that it is not. We know that there are very definite limitations put into the program.

Senator MURRAY. Yes.

Reverend McGOWAN. One of the limitations, I would like to point out, would be pretty well clarified, I believe, if we read pages 106 and 107 in their entirety. All of us having the bill, there is no point in boring you with reading it. However, I would like to point out this:

> After consultation with the advisory council, by regulation designates as auxiliary services—

and there "auxiliary services" is a very dubious area—

> auxiliary services on the basis of its finding that their provision under this title is practicable and is essential to good health care.

Someone must decide first off if it is practicable, and secondly, if it is essential; and then we go down to line 9:

> Medical services, hospital services, and, except as otherwise provided in subsection (b) of this section, all other personal health services specified in section 701 shall be made available as benefits to eligible individuals in all health-service areas within the United States as rapidly and as completely as possible, having regard for the availability of the professional and technical personnel and the hospital and other facilities needed to provide such services.

Once again we are all agreed that that is the logical approach. It certainly limits complete health care immediately for all the American people.

Senator MURRAY. The only way it could be put into operation is step by step.

Reverend McGOWAN. Precisely.

Senator MURRAY. And if the theory of compulsory insurance and a national system is correct, that is the only way we could ever put it into operation.

Reverend McGOWAN. That is true; and, despite this step-by-step business, the fact remains that since 1912 England has had about 50 percent of its population covered by some sort of compulsory health insurance.

Senator MURRAY. Since 1912?

Reverend McGOWAN. Since 1912, Senator Murray, yes; and on July 5, 1948, they made the thing universal, and they are, to say the least, having a few headaches.

Senator MURRAY. Well, I never heard of voluntary insurance myself until about 7 or 8 years ago when we started agitating in this country by filing this bill.

Reverend McGOWAN. And I think you have done a great service.

Senator MURRAY. I never heard of it in Montana. It may have been in existence out there. But in the city of Butte where I live I never heard of any system of voluntary health insurance. I had a health insurance policy from a private company, as I have said several times here, and I carried it a great many years, and I never had an opportunity to collect a nickel on it, and they canceled it on me when I got to be 65. That is the only type of health insurance I have heard of before we started this agitation here for national health insurance.

Reverend McGOWAN. The company should have been liquidated forthwith. As a matter of fact, voluntary health insurance is not a new idea. It dates back to the thirteenth and fourteenth centuries, and it rather amuses me to hear people claim that Blue Cross is something brand new and that this voluntary method of neighbor taking care of neighbor is a modern idea. It existed centuries ago in the guilds of Europe when there was the full social life.

Senator MURRAY. Yes. Of course, it was a different world that we lived in than it is today. We did not have these big industrial centers in that period. It was largely agricultural, but today we have millions of people living in highly congested areas, with the danger of being thrown out of employment or the danger of getting a serious illness, and there ought to be some system whereby they can be taken care of.

Reverend McGOWAN. I think there should be, Senator Murray. I am not sure that we are going to arrive at it immediately, but I would like to throw in this observation: Some claim the very wealthy and the very poor receive good medical care. That is true, but with certain qualifications.

Senator MURRAY. Yes. I don't think the very poor get the excellent medical care that they talk about.

Reverend McGOWAN. The very poor do not even get the medical care that is available to them, because they do not go after it. When I returned from Rome my first 2 years in the priesthood was spent in the Cathedral parish in Boston, and there were in that parish several thousand people who were certainly medically indigent and many poverty-stricken, and almost within the shadow of their homes was the Boston City Hospital and the Boston Dispensary, now the New England Medical Center. The care was there for the asking, and some of them could pay for it, but they would not go; which brings us back again to the homely old adage: You can lead a horse to water but you can't make him drink.

Senator MURRAY. That is right. Thank you very much for your testimony, Father.

Reverend McGOWAN. Thank you, Senator.

Senator MURRAY. Have you any other questions, Senator?

Senator DONNELL. Yes. I would like to ask Father McGowan some questions.

Father McGowan, in your statement you call attention to the fact that a study was made by three Catholic organizations, a study of this whole problem.

Reverend McGOWAN. That is correct.

Senator DONNELL. The National Catholic Welfare Conference, the National Conference of Catholic Charities, and the Catholic Hospital Association.

Reverend McGOWAN. That is correct.

Senator DONNELL. Would you tell us, please, what is the National Catholic Welfare Conference, how large an organization, and what is the general function of that organization?

Reverend McGOWAN. Having had witnesses here before, it may be somewhat redundant or repetitious. However, in answer to your question, Senator Donnell, the National Catholic Welfare Conference is the voice of the Catholic Bishops of the United States of America.

Senator DONNELL. And the National Conference of Catholic Charities, what is that?

Reverend McGOWAN. The National Conference of Catholic Charities, of which the Right Reverend John O'Grady is the executive secretary, is a group of diocesan representatives who carry on the charitable work in the dioceses of the country.

Senator DONNELL. And the Catholic Hospital Association, that is the organization concerning which Monsignor Smith has testified?

Reverend McGOWAN. Of which Monsignor Smith is president.

Senator DONNELL. This booklet "A Voluntary Approach to a National Health Program," is issued by the bureau of health and hospitals of these three organizations; is that correct?

Reverend McGOWAN. No, Senator Donnell.

Senator DONNELL. What does that mean on the front page of it? It says "By bureau of health and hospitals of." What does that mean?

Reverend McGOWAN. There are three separate organizations.

Senator DONNELL. They are three separate organizations? What is the bureau of health and hospitals?

Reverend McGOWAN. The bureau of health and hospitals, NCWC, is the bureau of which I am the director.

Senator DONNELL. Oh, I see. Yes, sir. As to the amount of study which was put in upon this matter, I notice that Most Reverend Alter refers to that and says that:

> The bureau of health and hospitals of the social-action department, NCWC, the administrative board of the Catholic Hospital Association, and the directors

> of Catholic charities have given careful consideration to the varied phases of a national health program—

and so forth. We take it, therefore, that this report is not the result of just a hurried consideration of the problem, but is the result of a careful and comprehensive study that has been made by these various organizations; is that correct?

Reverend McGowan. As a matter of fact, Senator Donnell, as Senator Murry said at the hearings of 1946, no first draft of a bill is ever perfect. This published form is the sixth draft of our statement.

Senator Donnell. The sixth draft of this particular booklet. You referred also in your statement to the fact that—I may not quote you precisely, but if I do not, would you be kind enough to correct any error in my quotation?—that the administrative board of bishops had made some conclusions; is that right? Or just what did you say about that?

Reverend McGowan. I did not say that in my printed statement, Senator Donnell.

Senator Donnell. Not in your printed statement, but in your oral statement?

Reverend McGowan. In my oral testimony.

Senator Donnell. Just what did you say?

Reverend McGowan. That on April 26 the administrative board of bishops of the National Catholic Welfare Conference, in executive session, approved unanimously the little pamphlet which you hold in your hand.

Senator Donnell. Now, that body which approved the pamphlet, namely, the pamphlet entitled "A Voluntary Approach to a National Health Program," is that the governing body of the Catholic Church in this country, or does it express the opinion of the Catholic Church, or just what is its position?

Reverend McGowan. It expresses the opinion of the administrative board of the bishops. It is not the governing body of the church, Senator Donnell.

Senator Donnell. I see. But it expresses the opinion of that board of bishops?

Reverend McGowan. It expresses their opinion after study on the measure, to be specific.

Senator Donnell. How many bishops are there in the United States?

Reverend McGowan. I would say 148 or 150. I am not sure of that, however, plus, of course, the 4 cardinals and about 20 or 21 archbishops.

Senator Donnell. And their aggregate jurisdiction is the entire continental United States of America; is that correct?

Reverend McGowan. Correct. However, I would like to point out for the record——

Senator Donnell. Certainly.

Reverend McGowan. That each cardinal, archbishop, or bishop has his own diocese; is supreme in his diocese.

Senator Donnell. How was the action of this board of bishops taken which adopted the views set forth in this pamphlet?

Reverend McGowan. The action was taken after Bishop Alter, who wrote the foreword, presented the matter to the administrative board of bishops, and after discussion the bishops voted to approve this statement.

Senator DONNELL. Was that in a convention of bishops?

Reverend McGOWAN. That was in the meeting of the administrative board of bishops.

Senator DONNELL. And where and when was that had?

Reverend McGOWAN. On April 26, in Washington, D. C., of 1949.

Senator DONNELL. Do you recall approximately how many persons were present nad participated in that convention?

Reverend McGOWAN. Not having been there, I cannot say. I am rather inclined to say it would probably be 14 or 15.

Senator DONNELL. I see. Yes.

Senator MURRAY. Fourteen or fifteen?

Reverend McGOWAN. On the administrative board, Senator Murray.

Senator DONNELL. Then, how many members are there of the board?

Reverend McGOWAN. Fourteen—4 cardinals and 10 archbishops and bishops.

Senator DONNELL. So there were almost all of the bishops represented at this meeting?

Reverend McGOWAN. Yes.

Senator DONNELL. That is correct; is it?

Reverend McGOWAN. Almost all of the members of the administrative board.

Senator DONNELL. Almost all of the members of the administrative board.

Reverend McGOWAN. That is correct.

Senator DONNELL. Were participants in the meeting which approved this pamphlet entitled "A Voluntary Approach to a National Health Program"?

Reverend McGOWAN. That is right.

Senator TAFT. About how many bishops are there in the United States?

Reverend McGOWAN. I would say about 148 or 150 plus the cardinals and archbishops mentioned above.

Senator TAFT. One hundred and forty-eight plus the cardinals and archibishops.

Senator MURRAY. Well, they were approving it for the board. That is to say, as a board they were approving it. They were not approving it for the Catholic Church.

Reverend McGOWAN. They were approving it as a statement of the National Catholic Welfare Conference, which is the voice of the bishops in the United States of America.

Senator DONNELL. Now, Father, in this foreword by Most Reverend Bishop Karl J. Alter, I observe that he makes this statement, which I think is worthy of being specially noted in the record. He says:

> Ethical and religious ideals which furnish the highest motivation in the care of the sick as in all social service can function more effectively in voluntary associations than through the medium of the modern secularist state.

Do you concur in that view, Father?

Reverend McGOWAN. Absolutely.

Senator DONNELL. Going down into the body of the report itself, I notice on page 6—do yo uhave a copy of it before you, Father?

Reverend McGowan. Yes, I do, Senator Donnell.

Senator Donnell. I notice the preamble recites, at the bottom of page 6:

> Many competent authorities reject the policy of a compulsory Government insurance program which sets up definite controls (either expressed or implied) over hospitals, medical practitioners, dentists, nurses, and the auxiliary services concerned with the problems of health and sickness. Health care in the legislation proposed becomes practically a Government monopoly. It is recognized that some effort has been made to provide for voluntary and private initiative in determining the program but it reduces such efforts to a minor or subordinate role.

Do you concur in that expression as respects S. 1679?

Reverend McGowan. I certainly do.

Senator Donnell. Of course, I appreciate the fact that at the time this pamphlet was written that the reference is made here to S. 5, which is the earlier bill, but the same principles, I take it you would say, are incorporated in S. 1679.

Reverend McGowan. Precisely, and that gives validity to our statements, Senator Donnell. We antedated the new administration bill by, I think, 1 week. Ours was published on April 18, and the bill came out on April 25.

Senator Donnell. Yes, sir. There is nothing in S. 1679 that would cause you to abandon or change your views as expressed in this booklet?

Reverend McGowan. Nothing whatsoever, except——

Senator Donnell. And the views expressed in the booklet are equally applicable to S. 1679 as they are to S. 5; is that correct?

Reverend McGowan. That is correct, Senator Donnell, except that I would like to commend the administration bill for the fact that it does include in it, in contrast to the earlier bills, the titles that would provide for the development and support of medical schools, medical education, nursing, practical nurses, health centers, and all of the things which we feel are part of the total picture, and I feel that in writing this administration bill that a great contribution has been made to the fruitful discussion of an over-all national problem.

Senator Donnell. But, so far as the compulsory health-insurance features of Senate bill 1679 and Senate bill 5 are concerned, the observations made in the pamphlet are equally applicable to Senate bill 1679 as they were to Senate bill 5?

Reverend McGowan. That is right. If we were to rewrite it we would not change a word.

Senator Donnell. As to Senate bill 1679 you would not change a word in regard to the compulsory health features of that bill?

Reverend McGowan. Yes, sir.

Senator Murray. It is your opinion that the voluntary system will be able to provide the care that is necessary for the American people?

Reverend McGowan. Senator, it is my opinion that no program, voluntary, compulsory, or any combination of both, will ever take care of every problem of illness that there is in this Nation. I would like to feel that some day we will be rid of our cares and worries healthwise, but I do not see how it is possible as long as we are one day fated to die. I think we must remember this, too, Senator Murray: That in all this talk of health care and doctors' efforts, which we support very strongly, we must remember that doctors do not prevent death, they postpone it.

Senator MURRAY. Will not what?

Reverend McGOWAN. Doctors do not prevent death, they postpone it.

Senator DONNELL. And you have not thus far become convinced that it is necessary in order to provide the best practicable care and to solve as best as can be done practically—you have not become convinced that it is necessary to resort to compulsory Federal health insurance?

Reverend McGOWAN. That is correct, Senator.

Senator DONNELL. And that observation would apply in connection with what you said about Cardinal Mooney's statement. As I understood you to say, although the statement is in the words utered by Senator Murray this afternoon, the cardinal was only referring to a temporary situation?

Reverend McGOWAN. Precisely.

Senator DONNELL. And he was not advocating, as you understand it, a compulsory Federal insurance scheme as an ultimate solution?

Reverend McGOWAN. That is correct; yes, sir.

Senator DONNELL. Now, Father, at page 7 of the pamphlet it says this, near the top:

> On January 16, 1949, an independent and highly competent investigating agency, namely, the National Research Council stated that compulsory health insurance is not a major factor in the health of a country.

What is the National Research Council?

Reverend McGOWAN. That is a council, to the best of my knowledge, which has a reputation of being sound and reliable. That sentence was introduced into our statement by one of the representatives at the working committee. I have not investigated the National Research Council personally.

Senator DONNELL. It is a Catholic organization?

Reverend McGOWAN. I am quite sure it is not. I am sure it is nonsectarian.

Senator DONNELL. Now, you also quote the Brookings Institution in its report published in 1948. That is not a Catholic organization either, is it?

Reverend McGOWAN. Definitely not. It is also nonsectarian.

Senator DONNELL. Included in that—pardon me.

Senator MURRAY. I was going to say with reference to Brookings Institution, you would not say that the Brookings Institution would be an absolute authority for what the program should be?

Reverend McGOWAN. I certainly would not. I agree with you entirely, Senator Murray, and we could delete this statement of the Brookings Institution from our pamphlet without weakening it one iota.

Senator DONNELL. Although, Father, as you state at page 7, and I quote, in referring to the Brookings Institution, you say, "another highly competent investigating agency." You are not regarding it as infallible, but you do regard it as another competent investigating agency?

Reverend McGOWAN. I think that is a fair statement.

Senator MURRAY. It has a good reputation?

Reverend McGOWAN. Precisely.

Senator MURRAY. I do not think it justifies that reputation. I see they issued a study here a short time ago, and they recommended that our whole system of government be changed. They recommended that we set up some kind of a commission and abolish the House and make the Senate a sort of a House of Lords, and that program was sent out across the country by the Brookings Institution.

Reverend McGowan. I would not be competent to comment on that.

Senator Donnell. But, at any rate, Father, you believe and you believed at the time this pamphlet was prepared that the Brookings Institution was, to quote "another highly competent investigating agency"?

Reverend McGowan. I believe that is correct.

Senator Donnell. And included in a portion of this report which is set forth in this booklet is this:

> Compulsory health insurance would necessitate a high degree of governmental regulation and control over the personnel and the agencies engaged in providing medical care. This field of regulation and control would be far more difficult than any other field previously entered by the Government, and past experience with the governmental regulations and control in the United States causes doubt as to whether it encourages initiative and development.

Do you share in those views thus quoted from the Brookings Institution?

Reverend McGowan. Yes, Senator Donnell.

Senator Donnell. And then just a little further down in this sentence I notice you quote this sentence——

Senator Murray. The whole book is in the record, Senator.

Senator Donnell. I know, but I wanted to get this particular sentence in. It says:

> It would seem unwise at this time to substitute for these developments a system of compulsory health insurance by national law which would have the unfortunate tendency to freeze policies and eventually retard medical progress.

Do you share in that view so expressed by the Brookings Institution?

Reverend McGowan. Yes. Once again, Senator, to express a truth, I do not believe in tearing down the house because we have to repair a porch.

Senator Donnell. Yes. You spoke about this booklet being the sixth draft. Who was it that prepared it? I do not mean the name of the individual particularly, but was it a number of men who worked on this bill?

Reverend McGowan. Yes. The people who prepared it were official representatives of the three organizations whose names appear on the cover.

Senator Donnell. How many people would you say participated in the preparation of this booklet?

Reverend McGowan. You mean in remote preparation, or immediate preparation?

Senator Donnell. Well, in any respect.

Reverend McGowan. In the remote preparation it would be hundreds.

Senator Donnell. And in the immediate preparation?

Reverend McGowan. In the immediate preparation it would be approximately 26.

Senator Donnell. So hundreds of people participated in the remote preparation which was, in turn, submitted to a smaller group, about 26, who participated in the actual preparation of the booklet; is that right?

Reverend McGowan. Yes. This is the distillation of years of thinking on this subject.

Senator Donnell. Yes. Now, I want to ask you this: It states over on page 8 of this booklet:

> It is not so much the principle of taxation for health protection which is opposed. Rather it is the monopoly which would be the inevitable result under the Government system, and the misnomer of calling the tax an insurance.

Now, I want to ask you two questions on that: First, do you share the view that monopoly would be the inevitable result under the Government system?

Reverend McGowan. Pardon me, Senator Donnell. May I answer that by saying I share every view that is expressed in this pamphlet from cover to cover.

Senator Donnell. Very well. And the misnomer of calling the tax an insurance, why is it you regard that as a misnomer?

Reverend McGowan. I think that was amply demonstrated a few days ago before you honorable gentlemen when the American Medical Association testified—not that we identify ourselves, however, with the American Medical Association.

Senator Donnell. I understand. You are testifying entirely independently.

Reverend McGowan. Precisely.

Senator Donnell. And your statement here is very succinct and says:

> Insurance, according to accepted terminology, implies uniform and specific benefits supported by standard adequate reserves proportioned to premiums: Definite actuarial basis in determining cost of benefits; voluntary election of the protection offered.

Then you conclude that paragraph with the words:

> The proposed compulsory Government health insurance system has none of these features.

Father, have you, since this pamphlet was issued, changed your mind in any respect with reference to what I have just read about calling the tax an insurance?

Reverend McGowan. No.

Senator Donnell. Now, the next paragraph—I will not read it in full—refers to the point that the Senate bill No. 5 could not fulfill its promises under existing shortages of personnel and institutional facilities. Is it your opinion that neither could S. 1679 fulfill its promises under the existing shortages of personnel and institutional facilities?

Reverend McGowan. Senator, in the interest of the gentlemen who wrote the administration bill, I feel that they have spelled out the limitations of the bill and actually have not promised a pie in the sky, and I feel that they have made a very sensible approach to the chronological attack on the health problem.

Senator Donnell. There is, however, an existing shortage of personnel and institutional facilities which would make it extremely difficult to provide all these services set forth in S. 1679; is that right?

Reverend McGowan. To provide them at once is impossible. To provide them in time is quite possible.

Senator Donnell. Now, Father, you say over on page 9:

> We submit that a program of service by voluntary associations and private initiative backed by Government financial support is more in keeping with this sound social principle than a Federal compulsory health insurance system.

Would you just amplify that view a little and tell us why it is that you think that a program of service by voluntary associations and private initiative backed by Government financial support is more in keeping with the principle to which you refer than is a Federal compulsory insurance system?

Reverend McGowan. To be as brief as possible, I shall repeat what I said before Senator Donnell: The basic philosophy of society is that the Government should not do for its people what the people can do for themselves.

Senator Donnell. Then, at the top of page 12, you say this:

> We recognize that so far medical benefits are inadequate, but we do not admit that they cannot be improved and made comprehensive for the American people within a reasonable future, without resorting to compulsory Government health insurance.

You still have that view today, as you testified heretofore; is that correct?

Reverend McGowan. Absolutely.

Senator Donnell. And then near the conclusion of page 12 you point out that:

> It should not be overlooked furthermore that the compulsory Government health insurance system makes only vague and general but no definite and concrete provisions for the medically indigent who constitute a large part of the problem of national well being.

And I take it that your observation there applies both to S. 1679 and to S. 5; am I right?

Reverend McGowan. Yes; I think that is true, with the proper qualifications, as Senator Murray has pointed out: They have the intention of taking care of the medically indigent. However, the responsibility has been thrown back on the States.

Senator Donnell. Then over on page 18 down at subdivision D you refer to a recommendation set forth that there be authorized and appropriated by Congress the sum of $10,000,000 to assist the individual States to make available a system of prepayment of costs of hospital, medical, and surgical care for their respective areas. While I understood from Monsignor Smith that he—I assume it is true of you: That while you are not in a position to express yourself at this moment with reference to the Taft bill, you do know that the Taft bill does provide grants-in-aid to the States?

Reverend McGowan. Yes, Senator, and I have read the Taft bill, the new one and the old one.

Senator Donnell. And both of those bills contain that principle and are based in large part thereon?

Reverend McGowan. That is correct.

Senator Donnell. Now, finally, over in the conclusion set forth at page 20 of the booklet you say: "The proposed legislation of S. 5"; I may take the liberty of inserting "S. 1679"; may I not?

Reverend McGowan. Yes, sir.

Senator Donnell (reading):

> Presents a highly complicated system of directing, regulating, and controlling health services which in the judgment of hospital authorities and medical men would be practically unmanageable and which would so increase demands on existing facilities and personnel that the very weight of the premature demand would necessarily cause a deterioration of the quality of the services rendered.

Father, are you at this present time actively engaged in this hospital work?

Reverend McGowan. I am the director of the bureau of health and hospitals.

Senator Donnell. You are the director of it, and you have supervision of all these hospitals throughout the country; is that right?

Reverend McGowan. I am the director in an advisory capacity.

Senator Donnell. Mr. Chairman, may the record at this time show that through the courtesy of Monsignor Smith I am informed that the correct name of the hospital at Maryville, Mo., is St. Francis Hospital.

Thank you very much, Monsignor. I have elevated you already.

Senator Taft. Father McGowan, I am very sorry to have missed your testimony. I had a policy committee meeting that I had to attend. I only wanted to ask one thing: I was very much interested in this proposal about tax deductions. That is one of the outstanding differences, so to speak, in other plans that have been suggested. As I understand it, that is a deduction of the premiums paid for health insurance, that is, for hospital and medical insurance, I assume.

Reverend McGowan. According to what insurance the person carries, Senator Taft.

Senator Taft. Yes; up to $75, which is to be deducted from the tax, not deducted as the medical expenses are under the bill when they exceed $50?

Reverend McGowan. That is correct.

Senator Taft. But it is to be deducted from the tax itself?

Reverend McGowan. Yes.

Senator Taft. A credit, therefore, on the tax. I was somewhat doubtful when I read it. The word "deductions" ordinarily used here means deduction from the gross income under the income-tax law. I think we would have great difficulty in ever getting the Treasury to agree to such an extreme deduction. It would mean in effect that then the Federal Government is paying the tax. But I do think something might be worked out. I think perhaps the credit-on-the-tax idea for some proposition of this could well be advanced. Our health committee here will have to advance it pretty strenuously if we expect to get through the Finance Committee on that.

Reverend McGowan. May I speak to that point, Senator Taft?

Senator Taft. Yes.

Reverend McGowan. I think our proposal of the $75 deduction from the payable income tax takes on somewhat the character of Senator Murray's bill on compulsory health insurance. It is a catalytic agent. I do not feel that it is going to be adopted. As a matter of fact, I repeat, we are not writing legislation at all. It is not our prerogative. However, it was put in there as strongly as it is to indicate our sincerity and our intense interest in stimulating the voluntary approach to this program.

Senator Taft. I would not have any hesitation in advocating strongly the deduction of this insurance from gross income. The trouble with that is, as you no doubt considered when you prepared it, that it does not take off very much tax, and it takes off less tax for the low-income fellow than for the high-income fellow. I think, if you could get even a credit of $25 on the tax itself, that it would be a tremendous inducement. I think it is something that ought to be considered.

You spoke also—you may have before this—of suggesting that this was not a bill. I think I can say, so far as I am concerned, and no doubt the whole committee feel that they will treat it as if it is a bill. We have got about four different proposals now for voluntary insurance and voluntary health treatment, medical care, and improving the present system without compulsory health insurance, and we certainly are going to treat yours as a fourth bill, now, in addition to the others, when we try to put them together. I hope we can get all the advocates of the voluntary approach to agree, and, with your consent, we will treat this as a bill, even if you have not put it in the form of a bill.

Reverend McGowan. I rather doubt that we can, Senator Taft. You know that old saying that whenever any two men in the same business always agree one of them is unnecessary.

Senator Murray. Father, you base your whole position on the proposition that the Federal Government should not do anything for the people that the people can voluntarily do for themselves?

Reverend McGowan. Precisely.

Senator Murray. You will admit, of course, that there will be a considerable division of opinion in the country with reference to whether or not this can be accomplished in a voluntary method?

Reverend McGowan. That is why we are here, Senator Murray. It is a difference between men of good will.

Senator Murray. And you would have no objection to me feeling, after the long study that I have given to this subject, that a voluntary system will not do and that we must have a compulsory system?

Reverend McGowan. That is one of the pleasures of working with this group, Senator Murray, and I want to put in the record my own personal gratitude for the very cordial and gracious reception that you and Senator Pepper gave myself and representatives of the hospital field just a few weeks ago.

Senator Murray. You recognize that we were sincerely and honestly trying to find a solution to these problems.

Reverend McGowan. I said that then, and I repeat it now.

Senator Murray. Well, now, we have had a study made of the Brookings Institution report where they came to the conclusion that a voluntary system is the right system, and the conclusions that we arrived at and this study that we made is absolutely that the voluntary system will not work.

Reverend McGowan. I think the burden of proof, Senator Murray——

Senator Murray. I would like to read a paragraph from this conclusion.

Senator Donnell. Whose conclusion is this, Senator?

Senator Murray. I will give you the whole thing.

Senator Donnell. I just want to know whose conclusion it is.

Senator Murray. I will not tell you until I get through.

Senator Donnell. Very well.

Senator Murray (reading):

> Thus at first glance and viewed as a whole, it seems that the Brookings report recommends a policy of encouraging voluntary health-insurance plans, supplemented by a system of poor-man's medicine. On close inspection of the report, however, it becomes evident that the authors themselves doubt the sufficiency of voluntary health insurance. The authors continually insist that "most con-

sumer units" would have the capacity to pay for voluntary health insurance if "they would give medical care a high priority with a preference over expenditures for automobiles, alcoholic liquors, tobacco, recreation, and savings." At once, however, the authors go on to question the willingness of many consumer units to give this priority. Then, on page 187 of the report, we learn that health insurance may have to be made compulsory after all. A comparison is made with automobile-accident insurance which a few States have made compulsory on all car owners.

"This idea is then applied to health insurance. The State or National Governments," says the report, "could force people to give a high priority to the costs of medical care in family financing. It (the Government) can require that an individual and those dependent upon him shall be insured against the costs of medical care in a voluntary organization of his own choice."

There is a lot of compulsory business about this, it seems to me.

The voluntary insurance plan would have to be approved by a State or National agency; the individual might be given a choice between taking out such health insurance or he might have to "deposit in trust with an approved agency resources sufficient to meet maximum probable costs of medical care." (p. 187 of the Brookings Institution report). Faced with this choice, says the report, all but a few individuals would accept the first alternative of joining a "voluntary" insurance plan.

The authors then list five "advantages" of this proposal. It is suggested, for example, that "high administrative costs" would thus not fall upon the National Government. It is true, the costs would not fall on Government but they would fall on the people who had to join insurance plans and the costs would be very high indeed under such a system.

The criticism of the Brookings plan continues at some length. This study of the Brookings Institution program was made by Michael M. Davis, chairman, Committee on Research in Medical Economics, New York, and Dewey Anderson, executive director, Public Affairs Institute, Washington.

I ask that the entire report, A Review of the Report of the Brookings Institution, be placed in the record.

(The document referred to will be found in the files of the committee.)

Senator DONNELL. Mr. Chairman, may I also have leave to have inserted in this record at this point a copy of the pamphlet, A Statement of the Issues and Conclusions from a Study by the Brookings Institution also?

Senator TAFT. It will require a lot of extra printing to put them in the record.

Senator MURRAY. No. I ask to make them a part of the record.

Senator DONNELL. Without printing it.

Senator MURRAY. Yes.

(The document referred to will be found in the files of the committee.)

Senator DONNELL. I would like to read this excerpt from Brookings Institution's conclusions, on page 11:

9. Compulsory health insurance would necessitate a high degree of governmental regulation and control over the personnel and the agencies engaged in providing medical care. This field of regulation and control would be far more difficult than any other large field previously entered by the Government, and past experience with governmental regulations and control in the United States causes doubt as to whether it encourages initiative and development.

10. The problem of eliminating politics from Government administration is extremely difficult. It does not seem probable that politics could be eliminated from medical care supplied under a governmental system.

11. Compulsory insurance would inject the Government into the relationship between practitioner and patient. A real danger exists that Government actions would impair that relationship and hence the quality of medical care.

And finally:

12. The administration of compulsory insurance would require thousands of Government employees for accounting, auditing, and inspection and investigation.

Reverend McGowan. Mr. Chairman, may I say one word at this point: I do not want our groups to be tarred by the brush of ignorance, and I certainly do not want the impression left that we feel that Government has no place in medical care. We know that the Federal Government has 51 percent of the hospital beds of the country, and we know that it is governmental responsibility at whatever level one chooses to take care of tubercular patients and of those mentally ill, and for these two very good reasons: The security of the state. First of all, we take care of the tubercular and those with communicable diseases because they threaten the health of the state, and we take care of those unfortunately afflicted with mental illness because they threaten the very life of the citizens of the state, so that we have no objection to the splendid Government job that has been done for those people.

Senator Murray. Social security, too.

Reverend McGowan. Yes, somewhat.

Senator Murray. Well, talking about the Brookings Institution study, Dr. Meriam, who headed the Brookings Institution 2 years earlier, took the position that our whole social-security approach is no good and that we should go back to the old system: Let everybody take care of himself.

Senator Taft. I do not think, Senator, that is a fair statement of what he said at all. He did not approve of social insurance as a method of dealing with social welfare. That was his general philosophy. But he did not have anything to do with this report.

Senator Murray. His position was that everybody should take care of himself: The wise man thrives on adversity, but a fool rides to destruction on the wages of prosperity.

Senator Taft. Well, that was not his statement, Senator.

Senator Murray. Of course. I did not say it was his statement.

Senator Taft. Nor was it his thought.

Senator Murray. A rugged individualist is to rule in this country and the wise man can take care of himself and the fool, you do not need to pay much attention to him.

Reverend McGowan. He would not agree with Professor Harris of Harvard who testified before you a few days ago.

Senator Taft. As a matter of fact, that is not Professor Meriam's opinion, so I would not like to let it go by.

Senator Donnell. I may say, Senator Taft, that Dr. Meriam did have something to do with this report.

Senator Taft. Oh, he did?

Senator Donnell. Yes; and the responsibility for the study was entrusted to two professors of the institution, Dr. Meriam and Dr. Bachman. Dr. Merian participated with Dr. Bachman in that.

Senator Taft. According to that statement Mr. Moulton is the man.

Senator Murray. You are through with the witness?

Senator Donnell. Yes, sir.

Senator Murray. Thank you, Father. I appreciate your appearance here today. It has been very interesting.

Reverend McGowan. Thank you, Mr. Chairman, and the honorable members of the committee.

Senator Murray. We will recess until 10 tomorrow morning.

(Whereupon, at 4:45 p. m., the subcommittee adjourned, to reconvene at 10 a. m., Thursday, June 2, 1949.)

(Subsequently Senator Murray submitted the following correspondence for inclusion in the record:)

May 21, 1949.

Hon. John W. Snyder,
Secretary of the Treasury, Washington, D. C.

Dear Secretary Snyder: I should like very much to have the comments of the Treasury Department on a plan that proposes that income-tax deductions be used as incentives for low- and middle-income groups to join voluntary health-insurance programs.

I enclose a copy of a pamphlet entitled "A Voluntary Approach to a National Health Program," which contains this proposal. In addition to your comments on the administrative aspects of such a plan, I should also appreciate it if you would furnish me with an estimate of the number of persons that would be eligible in 1949 for income-tax exemptions under this proposal and an estimate of the loss of income-tax receipts that might result from the proposed reductions. Some estimates for 1948 are made in the attached memorandum, and you might want to comment as to their accuracy.

The merits of this particular proposal will come up for consideration by my Subcommittee on Health in the course of our forthcoming hearings. I should, therefore, appreciate as early a reply as is convenient.

Sincerely,

James E. Murray.

Treasury Department,
Washington, June 30, 1949.

Hon. James E. Murray,
United States Senate, Room 121, Senate Office Building,
Washington, D. C.

My Dear Senator: This is in further reference to your letter of May 21, 1949, requesting the comments of the Treasury Department on the plan of the Catholic Hospital Association to use income-tax deductions as incentives for low- and middle-income groups to join voluntary health-insurance programs. The plan proposes allowing premiums for health insurance (up to $75 per year) to be deductible as a credit directly from individual income-tax liability in the case of individuals or families with gross incomes of $5,000 or less.

Since the proposal calls for a direct income-tax credit, it would mean in effect that the Government would be underwriting 100 percent of the cost of health insurance for families paying sufficient tax to cover health-insurance premiums. At the same time administration of this health insurance, even though 100-percent Government-financed, would be entirely in private hands. It is questionable whether thus allowing public funds to be privately administered, without at least the establishment of definite standards to which the private health plans would be required to conform, would represent a desirable direction of public policy.

The plan is also objectionable on equity grounds. Full benefits would be available only to families with incomes below $5,000 but paying more than $75 in tax. Thus the plan would discriminate against large families in favor of small ones. Moreover, the plan is inequitable in that it would underwrite the cost of health insurance only for families paying income tax. It would seem, however, that families paying no tax at all or having tax liabilities less than the cost of health insurance should be encouraged quite as much to join health-insurance plans as those families with higher tax liabilities.

With the exception of extraordinary medical expenses for which special emergency relief was provided in the Revenue Act of 1942, the Federal income-tax law has always made provision for personal, living, and family expenses by way of personal exemptions rather than through specific deductions therefor. In this way the inequity that would surely result from a discrimination between different classes of personal expenditures has been effectively avoided. This proposal, like other proposals which would grant special income-tax treatment to particular groups of persons or to particular programs, would tend to undermine the equity of the individual income tax.

Another serious objection to the plan is the potential loss of revenue that would result from its enactment. It is estimated that in the year 1949 approximately 38,000,000 taxable returns would be eligible for the credit provided under this program. It seems not unreasonable to expect that virtually all of these returns would take advantage of the credit if it were provided. While not all taxpayers could claim the full credit, the net revenue loss would be of the order of 2.4 billion dollars. This agrees quite closely with the comments on the pamphlet attached to your letter and is considerably higher than the estimate of cost by the authors of the program.

Although the plan would raise no new administrative problems, it would represent an additional burden on the Bureau of Internal Revenue. Since the plan calls for a direct tax credit, it would appear desirable to treat this credit in a manner analogous to the present treatment of taxes withheld on wages and salaries. This would imply requiring proof of payment of health-insurance premiums on the part of taxpayers claiming credit. Such proof could take the form of a statement similar to Form W-2, which would be attached by the taxpayers to his income-tax return. Duplicate statements would also be required from the health-insurance groups covering each taxpayer who had paid premiums to that organization. These forms would be processed in essentially the same manner that withholding statements are now handled by the Bureau. The work load in handling some 38,000,000 additional documents and in checking these against tax returns would be considerable and would add further to the cost of the program. A direct tax credit for health insurance or any other purpose would also raise problems for the existing system of income-tax withholding. If the existing withholding table was used, many taxpayers would be entitled to refunds because of this credit. On the other hand, if the withholding schedule were revised to allow for this credit, taxpayers not taking advantage of the credit would be subject to underwithholding.

I hope that these comments will be helpful in your consideration of this proposal. If there is further information you would like to receive, please do not hesitate to write us again.

Sincerely yours,

JOHN W. SNYDER,
Secretary of the Treasury.

COMMITTEE FOR THE NATION'S HEALTH, INC.,
New York, N. Y., May 16, 1949.

Senator JAMES E. MURRAY,
Senate Office Building, Washington, D. C.

DEAR SENATOR MURRAY: I enclose memoranda in response to your request for factual comment on the pamphlet, Voluntary Approach to a National Health Program, issued by the bureau of health and hospitals of three Catholic organizations. I hope these may be of some use to you.

It occurs to me that some helpful comments on the administrative aspects of the pamphlet's income-tax-deduction proposals might be obtained if you wrote the Treasury Department.

Sincerely yours,

MICHAEL M. DAVIS.

COMMENTS ON THE PAMPHLET "VOLUNTARY APPROACH TO A NATIONAL HEALTH PROGRAM"

(Issued by the bureau of health and hospitals of three Catholic organizations)

I. LARGE UNDERESTIMATE OF COST

The pamphlet proposes that people be encouraged to join voluntarily health-insurance plans by being accorded a deduction from their income tax, up to $75, provided their income is under $5,000. The pamphlet estimates that the cost of this to the Federal Government in income-tax receipts would be approximately $1,500,000,000 a year.

A correct estimate of the potential cost to the Government would be $2,500,000,000 at least, possibly as much as $3,000,000,000, instead of $1,500,000,000. The attached memorandum explains the basis of this correction.

II. THIS TAX CREDIT PROPOSAL WOULD HAVE MANY INEQUITIES

Large families would be discriminated against. For example, a single person, or a childless couple, with an income of $3,000 would be able to take full advantage of the $75 tax deduction to pay their premium in a voluntary insurance plan. On the other hand, a family of four with this income could offset only $54 instead of $75, because their total income tax would be only $54. A family of five would get no benefit at all, because with their exemptions no income tax would be due.

Again, small-business men and other self-employed persons who incurred a loss during a particular year would have no income tax to pay and would receive no benefit from the proposal, although under these circumstances they especially need the protection. Many families whose income tax is less than $75 could derive only partial benefit.

The table in part II of the accompanying memorandum shows the family income groups which would receive no benefit from the proposal and those which would receive only partial benefit (less than $75).

III. INADEQUATE FUNDS ARE PROPOSED FOR AID TO LOW-INCOME PERSONS

The pamphlet proposes (p. 18) that $200,000,000 be appropriated from general Federal revenues to assist the States in providing health care for persons who, because of low income or the absence of income, do not qualify for the income-tax deduction.

Even assuming that the States match the $200,000,000 Federal contribution dollar for dollar, only about 8,000,000 persons could thus be cared for. The number of eligible persons, including persons gainfully employed and their dependents, however, would be over 50,000,000. (Pt. III of memorandum supplies details.)

Memorandum in Explanation of Errors on Pages 17 and 18 of Pamphlet "Voluntary Approach to a National Health Program"

I. COST TO GOVERNMENT OF INCOME TAX DEDUCTION

The pamphlet estimates (p. 17) that there would be 21,000,000 gainfully employed persons who would pay taxes on incomes less than $5,000 and who would, therefore, be entitled to a deduction up to $75 from their tax. The cost to the Government in loss of receipts is, therefore, estimated at about $1,500,000,000.

The number of persons earning less than $5,000 and paying income taxes is, however, much larger than 21,000,000. In 1946, the most recent year for which data are available, there were 49,500,000 income-tax returns filed on incomes less than $5,000. About 15,000,000 of these were not taxable returns because of exemptions, etc., leaving about 35,000,000 who would have received the benefit of the deduction. A $75 deduction for each would have cost $2,600,000,000, or $2,500,000,000 if allowance is made for those with tax liabilites under $75.

In 1948 it is probable that about 36,000,000 joint and separate returns reporting incomes below $5,000 will be taxable. The $75 deduction for these 36,000,000 would result in a loss in income-tax receipts of over $2,500,000,000. If the tax credit were allowed per income recipient, thereby encouraging separate returns, the loss in income-tax receipts might well be as much as $3,000,000,000.

The pamphlet states (p. 17) that of 60,000,000 employed persons about 18,000,000 earned more than $5,000 per year. This 18,000,000 figure is much too large. It is 30 percent of 60,000,000. The last Census Bureau estimate of incomes (1947) shows only 5.4 percent of income receivers with individual incomes over $5,000. Thus, the figure 18,000,000 would have been between five and six times too large in 1947. In 1948, a rough estimate indicates that it would be between four and five times too large. In 1948, about 3,500,000 income recipients would have adjusted gross incomes of $5,000 and more, and (under the income-splitting provisions of the Revenue Act of 1948) about 4,000,000 taxable returns reporting incomes of $5,000 or more might be expected.

II. Incomes and exemptions not taxable and taxable at approximately $75 under the Revenue Act of 1948

Number of exemptions	Column (1) Income not taxable up to—	Column (2) Income taxable at $75 or more
1	$675	$1,175.
2	$1,325	$1,825.
3	$2,000	$2,500.
4	$2,675	$3,150.
5	$3,350	$3,850.
6	$4,000	$4,500.
7	$4,650	Over $5,000.
8 or more	Over $5,000	Do.

Source: Form 1040 tax table.

(NOTE.—Families with incomes less than stated in column (1) would get no benefit from the proposal. Families with incomes between the amounts in columns (1) and (2) would get only partial benefit, that is, less than $75.)

III. HOW MANY PERSONS COULD BE SUPPLIED MEDICAL CARE BY THE $200,000,000 FEDERAL APPROPRIATION RECOMMENDED?

Apparently it is the intent of this proposal to provide care for persons who could not benefit by the income-tax deduction. The pamphlet does not specify that the Federal appropriation of $200,000,000 must be matched by the States. This may have been intended. For the purposes of this analysis it is assumed that the States would match the Federal appropriation dollar for dollar, making a total annual fund of $400,000,000.

The pamphlet proposes (p. 18) that the funds should be "made available for the purchase of Blue Cross, Blue Shield, and other forms of voluntary health care." This statement would lead one to think that the intention is to pay the premium charges of Blue Cross and Blue Shield plans in behalf of the low-income persons to be served by this proposal. However, in the next sentence it is stated that State health agencies are to "establish a program to purchase service on a basis of payment of costs for hospital service and on a fixed fee basis for medical and surgical service." This means that the actual cost of hospital service would be reimbursed to the hospital out of the Federal or Federal-State fund, and that the physicians and surgeons furnishing care to eligible persons in the hospital would be paid according to a fee schedule.

Payment on this reimbursement basis would cost much more than if only the usual premium charges of Blue Cross and Blue Shield plans were paid in behalf of these persons. It is not quite certain from the pamphlet (par. C, p. 18) which policy is intended. However, it does seem certain that the hospitals could not afford to care for these persons at the regular Blue Cross and Blue Shield rates. The care of low-income persons for hospitalized illness costs substantially more than for the population as a whole. These persons require more hospitalization and their average length of stay in hospitals is longer. The reimbursement basis would be necessary in order to be fair to the doctors and hospitals. The only alternative would be a much larger premium charge. In either case, the cost would average about double the usual Blue Cross-Blue Shield premium charge, i. e., about $50 per person per year.

At this rate, $400,000,000 would provide for only 8,000,000 persons. The Federal funds alone would provide for only half this number.

About 70,000,000 individuals have some earnings during the course of a year. Perhaps 75 to 80 million individuals receive income from earnings, rents, interest, etc. On the average there are 1.8 persons (including dependents) for each income recipient. If the lowest income groups have the same number of dependents on the average as the population as a whole, the 30 to 35 million income recipients not taxable under the 1948 income-tax law and their dependents would number 54 to 63 million.

NATIONAL HEALTH PROGRAM OF 1949

THURSDAY, JUNE 2, 1949

United States Senate,
Subcommittee on Health of the
Committee on Labor and Public Welfare,
Washington, D. C.

The subcommittee met, pursuant to adjournment, at 10:05 a. m., in the committee hearing room, Senator James E. Murray (chairman) presiding.

Present: Senators Murray and Donnell.

Senator **Murray**. The hearing will come to order. The first witness this morning will be Dr. R. H. Hutcheson, president of the State and Territorial Health Officers Association and Commissioner of Public Health, Nashville, Tenn.

STATEMENT OF R. H. HUTCHESON, PRESIDENT OF THE STATE AND TERRITORIAL HEALTH OFFICERS ASSOCIATION AND COMMISSIONER OF PUBLIC HEALTH, NASHVILLE, TENN.

Dr. **Hutcheson**. Mr. Chairman, I have prepared and have submitted to the clerk copies of the testimony which I will give here this morning. I would like to read from the prepared manuscript, and if permitted to do so, inject a few extemporaneous remarks.

Senator **Murray**. All right, sir. You may proceed.

Dr. **Hutcheson**. By way of introduction, my name is R. H. Hutcheson. I am a graduate doctor of medicine, having graduated from the University of Tennessee School of Medicine. I hold a degree in public health (M. P. H.) from Johns Hopkins School of Hygiene. I am the commissioner of public health, State of Tennessee; president of the State and Territorial Health Officers Association; associate professor, preventive medicine, Vanderbilt University School of Medicine. My entire professional career in medicine has been in the field of public health and preventive medicine.

In presenting my testimony today I do so on behalf of the association of which I am president and for myself, personally.

The State and Territorial Health Officers Association is in members a small group composed of the official health officers of the several States and Territories. Affiliated with us are the directors of the mental hygiene programs and the hospital construction programs in those States in which the directors of the latter two programs are other than the official state health officer. I think there are about 20 of those altogether.

Before beginning my testimony, may I call your attention to the fact that we are all full-time employees of the several States and that our salaries are derived from public funds. We are specialists in the field of public health and preventive medicine. We believe we are in a position to know something about government medicine not in this country alone but in the world at large.

Most of us have had visitors. I know in my own State I looked over our register just before I came up here, and practically every one of the civilized countries of the world have sent visitors. The chief medical officers of health have been visitors to our department within the last 15 years observing the work that has been done there.

Many of us are old enough in years to have observed the changing attitude of the public toward the practice of preventive medicine and public health. As an association we want to commend the Congress on its attitude toward public health and its support of the program of public health and preventive medicine sponsored by those interested in this work, especially the American Medical Association, the United States Public Health Service, and certain of the philanthropic organizations, more particularly the Rockefeller Foundation and the Commonwealth Fund in our section. As an association we are interested primarily in public health and preventive medicine and, therefore, our testimony is presented with emphasis on those features of the several bills under discussion dealing with public health and preventive care rather than the medical and surgical care of the sick patient. Our objective is to reduce the load on the private practitioner and the hospital. In explanation of this statement, may I give you an example. When we find (as we often do) in our routine venereal disease clinics a patient with preclinical (beginning) symptoms of central nervous system syphilis and treat that patient in one of our rapid-treatment centers, we know we are rendering a personal service to the patient and doing society far more good, and are saving the taxpayer a great deal more money, than could possibly be done were the patient allowed to run the usual course, namely, develop central nervous system syphilis, run afoul of the police authorities, be committed ultimately to an institution for the insane and supported for the rest of his life at the taxpayers' expense. The same is true to a less degree in the early discovery of cancer, tuberculosis, diabetes, and other so-called preventable diseases.

Senator MURRAY. I suppose in some of the States you come across the disease known as silicosis.

Dr. HUTCHESON. Yes, sir; we do. We are attempting now in a number of the States—and mine I know better than any other, if you will permit me to use personal references—to X-ray as many of the people who are working in industry where they are exposed to silica to determine the present status of those individuals.

We have rather extensive equipment for the analysis of the air in which they work, the dust particles, et cetera, and when we find conditions that are apt to cause silicosis in the worker, we are making the necessary drawings for ventilation recommending to management of the industry that is concerned the mechanism by which they can eliminate the dust particles, and if it is such that it cannot be eliminated, we are doing what we can to see that the individual exposed is wearing a proper mask to protect him.

We are quite interested in it. We are carrying it along, Senator, with the general case-finding program that we use on tuberculosis because the method of diagnosing one is about the same as diagnosing the other.

Senator MURRAY. In earlier years it was quite a battle to get the various corporations or mines to——

Dr. HUTCHESON. To do anything about it.

Senator MURRAY. Introduce methods, ways, and means of protecting the miners from that disease. Does not silicosis occur in any industry where dust gathers?

Dr. HUTCHESON. Any industry where the dust has free silica in it. Of course you must have the silica in the dust.

Senator MURRAY. I remember at first that some of the corporations resented very fiercely the action of the people that tried to agitate for some relief for those kind of people.

Dr. HUTCHESON. Yes, sir.

Senator MURRAY. I remember when I first came here to Washington about 13 or 14 years ago I appeared before one of the committees here and told about silocosis conditions, and the corporations out there were very bitter about it.

Dr. HUTCHESON. Management is changing its attitude toward it now and actually I think we find more difficulty in getting the individual worker to comply with the regulations than in convincing management that it is in his interest to see that it is done.

Senator MURRAY. I know a great deal has been accomplished.

Dr. HUTCHESON. And a lot more needs to be accomplished.

In discussing the bills under consideration I should like the privilege of taking them up, first, according to their chronological number and, second, according to subject matter.

In item No. 1. S. 1106 by Mr. Lodge—this entire bill of 7 pages, except for 10 lines used to describe "medical aid," is devoted largely to the method of administration. We believe that the value of the service offered by payment from Federal funds is not worth the cost of administration necessary to carry out the intent of the act. The enactment of this bill into law would in many instances simply transfer the cost of services provided for in the bill from the local voluntary and official agencies and the State agency to that of the Federal agency together with the increased cost of administration at all levels.

We now have too many specialized services to account for and can see no justifiable reason for adding this one. We admit that there are hardship cases, but instead of loading this additional administrative cost on to the taxpayer, why not increase the general appropriation to the United States Public Health Service by one-fourth to one-half the amount estimated to be needed to implement this bill. Then, using the purchasing power of the United States Government, let the Surgeon General through his office buy the expensive medicines referred to and deliver them on requisition to the several State health officers who, in turn, can distribute them through the same channels now used for the distribution of diphtheria toxoid, typhoid vacine, smallpox vaccine, penicillin, and other drugs which are distributed by the several States.

It is routine practice now for us, gentlemen, to furnish a great deal of these things and we have the machinery now set up.

In addition to the cost of administration, we can see grave danger of misuse of certain drugs because of the public demand that the drug be used. Here we might cite as an example, streptomycin. In spite of its cost, this drug is being misused. If we are forced to make it available free of cost, certainly its misuse will be greatly increased.

Item No. 2. S. 1456 by Mr. Hill, Mr. O'Conor, Mr. Aiken, Mr. Withers, and Mr. Morse.

In general, the association approves in principle the purpose of the bill as expressed by Mr. Hill and others in similar proposed legislation, "* * * to make a high quality of hospital and medical care available to all persons. * * *" We believe in strengthening and coordinating existing health resources and encouraging voluntary enrollment in prepayment plans for hospital and medical care. We shall continue to fight toward this goal. To reach this goal, we must have first the personnel and facilities with which to work. There must be doctors in quantity sufficient to meet the demand for service and there must be adequately equipped and fully staffed hospitals with beds in numbers sufficient to meet the demand of the citizens who pay for hospital insurance with, and rightly so, the expectation of a bed being available on demand. Neither can now be guaranteed in a majority of the States.

Mr. Hill, together with his associates, has done much to help the several States start a hospital construction program.

I would like to emphasize the word "start" because when we have finished with the program as it is now set up, I think it is reasonable to say that not more than 20 percent of the actual need will have been met.

He and others have introduced legislation which will do more, and our association has offered testimony in support of this legislation.

We are ready and willing to do all we can to promote legislation designed to provide adequate hospital facilities. We are not willing to promote legislation that would take from the citizens of our States money in the form of insurance premiums for insurance covering hospital care when the hospitals are not now constructed and, therefore, the companies writing the insurance are unable to deliver through the hospitals the service bought by the policyholder. We believe that in most sections of the United States voluntary prepayment hospital insurance is being sold at a rate equal to the ability of hospitals to deliver service and in some areas, during periods of increased demand, the rate has exceeded available service.

We request that legal "stimulation" of voluntary enrollment in prepayment plans for hospital and medical care be postponed until such time as it can be shown that services are available on demand and then that such legislation is needed.

Senator DONNELL. Mr. Chairman, may I interrupt to ask Dr. Hutcheson this question. What is your present net conclusion as to S. 1456, the Hill bill, Doctor? Are you personally favorable to it or do you think it advisable to pass it?

Dr. HUTCHESON. Personally I think it is a little too early to ask that it be done because of the reasons that I have given. We are for the principles of the bill, and if it is needed, after we have shown that we have hospital facilities in numbers sufficient to provide the service, if the bill is needed I think that the association would go on record as favoring it.

Senator DONNELL. But you are inclined to the view that the bill presently is premature?

Dr. HUTCHESON. I think it is, and the association thinks so.

Senator MURRAY. And the reason for that is that you have not got the facilities?

Dr. HUTCHESON. We do not have the facilities.

Senator MURRAY. Or the personnel?

Dr. HUTCHESON. To produce the service, and we certainly do not have the personnel to produce it. Senator, the personnel is an acute thing. We have recently constructed, put into operation last November a 400 bed tuberculosis hospital in Tennessee. I have got 224 patients in it today, or Saturday morning rather there were 224 patients in that hospital. The rest of the beds are closed because we have not yet found the personnel to staff them.

Senator MURRAY. I notice in your statement you say that you are opposed to companies writing insurance where they are unable to deliver through the hospitals the services that is bought by the policyholder. Are there numerous cases of that kind where in certain sections of the country——

Dr. HUTCHESON. Opposed to the stimulation of companies writing the insurance, and that bill would be a great stimulus for the writing of the insurance which could not be delivered. If I get sick and if I hold a policy—and I have had this experience, Senator, with my son—I am entitled to a bed. I called every single hospital in Nashville and could not get a bed to put him in. They are willing to take him and the insurance companies are willing to pay for him if he can get in. Because I am a physician, they operated on him and put him in a utility room on a cot.

Senator MURRAY. Does that item apply to Blue Cross?

Dr. HUTCHESON. I am talking about Blue Cross.

Senator MURRAY. All right, proceed.

Dr. HUTCHESON. Item No. 3. S. 1581 by Mr. Taft, Mr. Smith, and Mr. Donnell.

Our association would like to have entered into the record our approval of the first statement of this bill—

> SEC. 2. (a) The Congress hereby finds and declares—
>
> (1) That health and medical functions are widely scattered through many agencies in the Federal Government with resultant confusion and duplication of effort—

and so forth.

On many occasions the association has taken official notice of this state of affairs. We have passed appropriate resolutions and, in general, complained to everyone likely to listen to us except possibly the President. We are glad to see that Senator Taft has intercepted our pass and, although he is running somewhat laterally, we are glad to do a bit of blocking for him.

We feel that the Public Health of the Nation is of paramount importance, and as a matter of pride we would like to see health established at the top of the list among the related services and the department responsible for its administration given Cabinet status.

Senator MURRAY. Do you think that the bill, S. 1581, sponsored by Senator Taft and others, could add to this confusion?

Dr. HUTCHESON. May I read on just a little further, and I think this will explain it. No, sir; I do not think it would at all. I think it would help some.

I call your attention to the fact that this status, that is that the Health Department itself, has a Cabinet status which prevails in many of the States.

In testifying before a similar committee of the Senate in 1947 (S. 545), Dr. Vlado A. Getting, of Massachusetts, speaking for this association, said, in effect, that under the present structure of the Federal Government, we felt that there was little chance of the creation of a separate Department of Health, and that we, therefore, as a second choice would support the creation of a combined Department of Health, Education, and Security, and presented an amended bill which would accomplish our second choice. We are still willing to make second choices and are especially gratified to see that this bill requires that the Administrator shall have demonstrated outstanding ability in the fields of medicine and administration. We want to go on record as stating, without fear of successful contradiction, that the present organization of the United States Public Health Service is sufficiently organized, staffed with well-trained specialists in all branches of medicine and allied arts and sciences, and, in general, big enough to be given the leading role in any reorganization plan. We know what anyone who will take the trouble to investigate superficially can learn, that no agency of the Federal Government has the respect of comparable branches of State government equal to that enjoyed by the United States Public Health Service. The reasons we believe are obvious. We would like to think that this state of affairs will continue.

Senator Murray. Do you think by strengthening and expanding the United States Public Health Service it would remove the necessity for many of these proposals?

Dr. Hutcheson. We would hope so. Now, here is where our biggest trouble is. We have the United States Public Health Service and we have—and I suppose, Senator, it is necessary; I do not know; I am not familiar with law at all—but we have a multiplicity of earmarked funds in the Public Health Service and in the Children's Bureau. As the State Health Officer I must submit budgets to the United States Public Health Service. I must submit duplicates of those same budgets to the Children's Bureau.

Do I have time to give an example?

Senator Murray. Yes.

Dr. Hutcheson. It is an actual occurrence when I first went into the central office of our State. I was director of the public health service, and the commissioner, Dr. W. C. Williams, asked me to assist in the revision of some budgets to use funds that were lapsing in the department because they had not been spent as set up originally. We had to have for nurses who were doing maternal and child hygiene work, and doctors who were doing that work, some automobiles, and we had to have for the doctors who were doing generalized programs at the State level and for the engineers who were doing sanitary engineering work in connection with the city water supplies, sewage systems, some automobiles, a total of six cars, and we had some State money necessary to match all of it, and we put in the requisitions.

The automobiles were delivered in due course of time, and being responsible for the assignment, I did not look at the motor numbers, the purchase orders, or anything else. I assigned one to the engineer, to the nurses, and down through the line. Two years later, I think it was, an auditor appeared on the scene, and he checked our purchases, and he found that I had assigned an automobile to an engineer that had been bought with Children's Bureau funds. He did not look to see that I had assigned one that had been bought with public health service funds to a nurse, and it took us about 6 weeks to get that thing straightened out, and it looked for a while as if I was going to have to pay for it.

It is just a lot of darn foolishness, that is all it is, at the local level, to have to administer things in that way, and I frankly think it ought to be under one—not an agency level head. We have got that now. There is practically no difference.

They moved the Children's Bureau over to the Federal Security Agency and I cannot tell any difference back there in Tennessee except that it may be a little bit more confusing.

Senator MURRAY. You think they should apply some of the principles of the TVA?

Dr. HUTCHESON. Well, I do not know much about the TVA and its administration, except I do know it has done a wonderful piece of work in the rural sections of the country down there; but I think that they need a bit more coordination in administrative affairs.

After all, listen, gentlemen, this is not in this testimony, but when we go out and do a good piece of sanitation work in a rural community, we are doing the children more good than we are the adults.

Those who have survived have become immune to most of the intestinal organisms that they are going to come into contract with, and the sanitation program is more important to the welfare of a child than a preschool examination is, and it is foolish not to consider it as such, and I think the whole thing ought to be administered for the welfare of the public at large, and I will tell you something else.

This possibly may be getting off the base, but we hear a lot about economy. I would be willing to take the money that is set up by the Federal agencies for grant-in-aid to the various programs in my State, put it all in general health, and cut it 20 percent, and I will do 20 percent more work than I am doing now, and I will guarantee. We have done it in the counties by organizing the program, setting up within a county district areas for a nurse to travel, and have increased the work she did by 15 or 20 percent and cut down her travel by an equal amount.

There is no earthly excuse for having specialized services, and we do not do it. We may be violating the regulations, but we set up a program for a rural health department, the nurse does all the work. She goes into a house. If it is a mother that needs looking after, she looks after her. If it is a child, she looks after the child and if it is an adult male, she does what she can there.

We do not have specialized services. If we actually followed the thinking that is, I believe, back of some of the appropriations for this, it would be possible for us to have seven different nurses calling on one family in one day. We do not do it.

There are professional shortages in the whole field of medicine and public health. To this shortage can be traced most of the complaints with regard to the total medical care and public health problem.

Senator, there, if I may leave the prepared text for just a moment, I have always felt that medical care is closely comparable to the commodity. If we have got seven doctors in a little town in Tennessee, and they are barely able to take care of the demand that is made on their time, people of course are going to feel that they are being neglected. If we had one more than was actually needed in the community, you would not have any trouble with medical care.

They would be cutting one another's throats in some instances possibly to get the patients to call them by any means that they could which was considered ethical, and if it were 12 o'clock at night or 2 o'clock in the morning, in spite of the fact that they may have worked already 12 hours, they would get up and go. It is the same thing exactly as if I have got 100 pounds of lard and people want 90 of it, then I am going to sell it cheap and I am going to see that everything is done to sell it. If they want 110 pounds and I have got 100, I am going to sit back and let them come to me, and that is exactly what is happening.

I am a physician. I respect the profession and think highly of the average man who holds an M. D. degree. We talk a whole lot about free enterprise in the medical profession. The people who are doing the scientific research and who are actually making the progress largely are people who are working outside of contact with the patient.

We do not have enough free enterprise. The individual doctor has a pretty good thing of it in his community because his services are in demand. He is working too much and he is seeing too many patients actually to do the job that he should do on that patient.

I visited my uncle 2 years ago just for the purpose of seeing what he was doing. He is what I call a country doctor. He is just 2 years older than I am.

I wrote him a letter and told him I was coming over and make every visit that he made. I was going to stay 2 weeks. At the end of 10 days I left and told him I had seen all I wanted because he was not treating diseases at all, but was treating symptoms. He did not have time to see the patient, and he ought to limit his practice to about half the load that he has.

He said, "I cannot do it. They call me in the middle of the night. They want to see me."

Senator DONNELL. Do you know about how many patients he has, Doctor?

Dr. HUTCHESON. Lord knows. I do not know. He did not tell me, but I know he worked from about 8 o'clock in the morning until 12 o'clock every night. Personally I could not stand up under it. Physically I could not take it at all.

Senator MURRAY. The number of patients that a doctor can take care of——

Dr. HUTCHESON. He was not doing any more than other men in the community were doing in which he lives. He was working in a community of about 7,000. Every man in the community was just as busy as he was. Some of the younger ones were doing more than he was. There are not enough to go around. That is the answer to the whole situation.

Senator MURRAY. And the real progress in the science of medicine is being made by men working on salaries in laboratories?

Dr. HUTCHESON. A good many of them, and a lot of them are not medics at all, but Ph. D.'s in their respective basic sciences; not all of them, but a large part of it is, and I think if you go back over the history of the thing, you will find that the United States Public Health Service and the Army and Navy have been responsible for a great deal of the advances that have been made.

The biological houses have done a great deal. They have all contributed their part. You have got, though, to have this general practitioner carry out these things in the field and put them to the final test to see if they do work.

Senator MURRAY. I was trying to prove that here the other day with Dr. Hawley on the witness stand, but he did not seem to fall in line with what I was trying to bring out, and he disclaimed that the Army had accomplished any great things.

It seems very strange to me. I thought that the medicine practiced by the Army and the discoveries that they have made were extremely beneficial.

Dr. HUTCHESON. Maybe he was unduly modest.

Senator MURRAY. Maybe that was it.

Dr. HUTCHESON. The methods used by various individuals in determining the extent of the shortage have varied and opinions have differed; however, most have been little better than guesses and we shall be glad of a chance to make a real study of the problem as it relates to availability of personnel and extent of need for increasing enrollment in professional schools. We should like to see assistance included not only to medical schools but also to dental schools and certain schools of nursing.

I did not elaborate on that, but in our State at least, the shortage of dentists is more than twice that of the medical profession.

Anyone who has attempted to secure an elective appointment with a dentist or employ nurses in any category will testify to the relatively greater shortage of personnel in these two professions as compared to medicine. Personally, I should like to see written into the bill a provision prohibiting assistance to any school operating for only a part of the year. No other business could hope to survive with capital investment equal to that of schools based on a production schedule of only about 8 months out of each year.

If they would go on a routine schedule, 12 months around the calendar, that in itself could produce about 25 percent more graduates. The University of Tennessee School of Medicine down in Memphis began year-round operations in 1930, and has been able to produce an equal quality and certainly a greater quantity of graduates. We used to admit 100 students to the freshman class. In the one that I attended there were 130. Seventy-two of them took the final examination. That is too great a mortality.

The students should be selected more carefully under the present plan. Of course, they could do the same thing under the other, and they all are selected more carefully. There is no criticism there. Those who are selected would go on through and not take up the place of somebody else who could have made the grade.

We are admitting now not 100, but 40 each quarter, which gives us 160 a year. We start out each quarter with actually one-quarter class, and I think the instruction is better. It takes more faculty, of course, but it does work, and I can see no reasonable excuse for all of them not doing it, and certainly we have got too much money invested in schools not to use it.

Our objections to the extension of hospital "insurance" have been voiced under discussion of S. 1456.

It is our understanding that favorable action has been taken by the Senate on school health legislation similar to that contained in this bill, and, therefore, no general comment is necessary. We do look with grave concern on the sharp line of demarcation between benefits offered the school child and lack of benefits for the preschool child, getting back to those MR programs again.

We are afraid, and with just cause, that there will be a tendency on the part of many parents to delay until school age needed services for preschool children. For example, our mortality rates indicate that the child who needs whooping-cough vaccine or diphtheria toxoid and does not get it during the infant or early preschool age may be in the cemetery and not at school when the school physician gets around to seeing him in school. A child should be gotten ready for school during infant and preschool age and not patched up after he reaches school.

It is my personal belief that this part of the bill is 20 or more years out of date. By careful analysis of the records of 50,000 school children followed, each one for a period of 5 years—Mississippi and Tennessee school children—by the Commonwealth fund, it was shown that the routine year-after-year examination of school children was about the least productive activity engaged in by a public health officer or school physician. We found, further, that unless a responsible member of the family, preferably a parent, was present, little good came of the examination or subsequent follow-up visits; that the most productive work of all was in the first grade with a parent present. Our program has been changed accordingly.

How, may I ask you, will these parents be with those children in those large consolidated schools? They will not be there.

By direction, we are omitting reference to titles IV and V; however, for the record, we want to reiterate that we are wholeheartedly in favor of both and have given testimony in support of each.

The association is opposed to the principle of compulsory health insurance and believes that such a program initiated at the national level should not be resorted to until all other avenues of approach, such as research, hospital construction, aid to education, extension of and complete coverage by local health services, and voluntary hospital and medical care programs, have been given the fullest opportunity under favorable conditions and proven inadequate to the needs of the people.

It would seem to us that the cart is being placed before the horse.

Senator MURRAY. Doctor, do you not think that the main problem in this country is the cost of medical care for the average citizen?

Dr. HUTCHESON. No, sir; I do not. I think the main problem is the lack of sufficient personnel to deliver medical care.

Senator MURRAY. Well, suppose you had adequate personnel and the people could not pay for it. What is the situation then?

Dr. HUTCHESON. Well, let us get adequate personnel, Senator, and then see what the cost is.

Senator MURRAY. Will that bring down the cost? Will that provide competition?

Dr. HUTCHESON. I have no doubt but that it would.

Senator MURRAY. I think there is some merit to what you are saying. I think that the scarcity of doctors in the country has contributed, because that is one way a doctor has to relieve himself of overwork. He raises his fees and then the people will not come to him so often.

Dr. HUTCHESON. Yes. I am going to inject this in there if I may. I have made no studies on it, but I have seen studies with reference to the comparable cost of medical care and other cost-of-living indexes, and the cost of medical care has not gone up anywhere near proportionate to the cost of living.

I am able to buy all the cigarettes I want and I am able to, if I want, to buy all the whisky I want.

The public does. That is what I am trying to say. The public does that without hurting themselves apparently too much, and I doubt seriously if it is a matter of cost as much as it is a matter of not wanting to pay the cost, and do without these other things that they have become accustomed to.

Senator MURRAY. But nevertheless, Doctor, the cost of medical care has gone up tremendously in this country.

Dr. HUTCHESON. Absolutely.

Senator MURRAY. Because of the advances in science.

Dr. HUTCHESON. That is right.

Senator MURRAY. Fifty years ago we did not have the operations that are performed today.

Dr. HUTCHESON. That is right.

Senator MURRAY. They are very expensive. We did not have many things that we have today, so that if we get the kind of care that is available now, you have to pay a great deal more for it than you used to pay in the case when the doctor used to treat the patient out of a little black bag that he carried around, so that the costs of modern medical care have gone up tremendously.

Dr. HUTCHESON. There is no doubt about it. It is great, but I still think that if we had an adequate supply of facilities, that the cost might—I do not know; I am no prophet, of course—be quite different, and that you and I might be willing to recast our thinking in regard to the needs.

Senator MURRAY. Well, right there, is there not a large number of doctors in the country that barely make a living because the people cannot employ them? They have not got the money to pay them with, and they neglect going to the doctors because they are afraid of the expense.

Dr. HUTCHESON. Senator, I am just a country boy.

Senator MURRAY. That is what I am.

Dr. HUTCHESON. From what is considered a rural State, and I have not met that doctor yet. Literally I know of no physician practicing in my State—and I know a good many in Mississippi and Alabama and adjoining States of Tennessee, and all of them that I know are making a pretty comfortable living.

In the cities like New York, there may be, but they are doing it by choice because there are plenty of places where we need them desperately and they could move out and make a better living.

Most of our membership, including members of our several staffs, know by reputation a majority of the physicians engaged in practice within our State. Some of us, especially those of us in States said to be in the most critical need of medical service, know by name a majority of the physicians engaged in active practice. We know few of these men who work less than 8 hours daily 6 days per week. I know many that do much more. Most of them plan to take Sundays off, but only a few are able to carry out this plan. Where, may we ask, will the extra time demanded of the physician come from? We hear much about the expression, "redistribution of physicians." Under what section of our Constitution can a law be passed that will force any physician to locate in any particular community in the United States?

Given a choice, the young physician will select as his future home a location that provides, first, social contact for himself and his family. Remember that he has spent 6 or more years in the best school environment in our Nation and 1 or more years in a top-flight hospital; therefore, he will judge social contact for himself by standards to which he has become accustomed. The majority will have acquired a family or are looking forward to acquiring one. For his family he will want educational advantages equal at least to the average to be found in the State of his residence; second, he will seek a location that provides hospital facilities adequate to meet the demands of his practice; third, he will inquire into the financial stability of the community; and, fourth, he will give consideration to the number of physicians practicing in the area. This latter doesn't appear to cause him a great deal of concern. He is young, optimistic, and secretly says to himself that he is the best in town and shortly will have all the practice he can take care of, and generally he does. How, gentlemen, are you going to persuade this young man to locate in a rural community with no hospital, no library, below-average schools for his children, poor in natural resources, and looking to the Federal Government for a hand-out? If you stop for a moment and put your son in his position, you know you are not going to achieve this goal with the means proposed in this bill.

This boy about whom we are talking has a commodity for sale. He is offering this commodity to the public, part in cash and part in kind. You must have both to make a purchase; and, as long as he receives enough cash to survive, he will stay where he is.

Senator, you have referred to the gentleman who in days gone by practiced from a black bag. We have some today who are doing it. They are compromising with their conscience. They have to, in order to do it.

They have been trained in a modern medical school with all of the facilities for diagnosis and all of the treatment, therapeutic gadgets that are provided in a modern institution.

He has been taught not only the art of medicine as was the man who attended medical school around 1900, but also the science of medicine, and that boy can no more practice medicine according to the manner in which he has learned to practice medicine in the rural community with a bag that he can get a stethoscope and a few other instruments in, a few pill bottles, than can a person who has worked for years in one of the modern automobile plants—Ford, for example—build a Ford automobile in a cross-roads blacksmith shop. It simply cannot be done.

He can guess, and his guesses frequently will be right, but there is no one to check him to see if he is wrong, and there was not anyone to check the older man. He has got to have these facilities to work with; and, unless they are out there in that community, he is not going to do it.

Senator MURRAY. You know, Doctor, that this bill (1679) that you are referring to contains various titles designed to accomplish that very purpose.

Dr. HUTCHESON. Surely I know it, and we are working toward that goal right now. The main thing is to construct the hospitals and get these boys trained to practice in them.

Medicine, pharmacists, nurses, dentists, dental hygienists, the whole field is short. We have got 75 vacancies in the State Health Department for doctors down in Tennessee right now, and cannot fill them.

Senator MURRAY. You have what?

Dr. HUTCHESON. Seventy-five vacancies in the medical personnel in the State health department and the county health services right today, and we are offering salaries twice or three times what we offered back in 1932, and they just laugh at me, and boys that I know, that I have checked on, are making less money than that in private industry.

It is not the money so much; it is the fact that they want to do practice in a city and community where they can do it according to manner in which they have been taught.

Senator MURRAY. Well, our bill (1679) recognizes that and contains various titles that seek to make it possible for these doctors to settle from other sections of the country where there is greater need for them, and where they are now lacking in proper facilities.

Dr. HUTCHESON. The thing we have got to do is build the facilities. There is no use in trying to get them to settle there without facilities.

Senator MURRAY. After you build the facilities and have them all set up, then you have got to figure out how you will get the people into them.

Dr. HUTCHESON. They will go there. We have a little county down there, Senator, that I think has about a population of 1,300. They have a good hospital in the community. A doctor built it himself, and they have got all the doctors they need to operate that hospital.

It is the only rural county in our State that meets the legal definition of need under the Hill-Burton bill. They have more than 2.5 beds per thousand population, and they say they have not nearly enough.

They have been educated to use the hospital. The doctor's time is conserved greatly by the use of that hospital. He is able to practice an excellent type of medicine and surgery, and they are getting splendid service from the men in that community who are the usual, or were when they began, the general run of practitioners in that community; and, if they had more space for patients, I venture to say there would be more doctors who would leave the urban areas.

They do not want to pay $3 a square foot for office space. They can get it out therefor $25 or $30 a month, and they would be happy to do it, and they would take less for their practice because they are doing it. We need the men first. I do not know just what we need after we get the facilities for them, but I think the other would come.

The only way in which he can be persuaded to move to the less attractive area is to push him out with men of his peers. If and when we train medical practitioners in numbers exceeding the demand in the more attractive areas, some will reluctantly seek the less attractive locations. As you make these locations more attractive by providing hospital facilities, more and more of the better qualified will move from the more urban to the rural areas.

Within a few years, acting under a purely voluntary plan, more than one-third (57,000,000) of the people of this country have bought hospitalization coverage. More than one-fifth (30,000,000) have bought surgical coverage. As service becomes available, others will buy similar plans; therefore, let us urge you to concentrate on hospital construction, coordinated hospital-service plans, training of personnel by grants to schools, if necessary (not scholarships to students for basic work), and extension of basic public-health services.

That is not needed. I think absolutely it would be the worst thing in the world that could be done because we have more than three men ready and willing to pay for medical education for every seat in every medical school in the United States today, and they are, as a rule, country boys who have come to town and want to go to medical schools in our section.

Of course, you have got the urban people here in the East and North, but I was on a committee once to grant scholarships to students given by one of the philanthropic agencies, and they required that this boy sign an agreement that he spend 5 years in a rural community after he graduated. They defined "rural" as a community of 25,000 or less. Every one of them lived up to the agreement, but every one that I came in contact with—and that was, I think, all of them, although I am not certain—felt that they had been placed in danger and, had they not been forced to go to this small community, they would have become a second Charlie Mayo, and they were dissatisfied and disgruntled and most, at the end of the 5-year period, moved away and went to town, and a great many of them turned around a year or so later and went back to the same community which they had left.

I think it would be wrong to pay this boy to go to school unless you are going to pay him to study other things, such as law. We are paying them now. No student pays his way. There are State schools and philanthropic agencies that subsidize him by grants to the schools and not to the students themselves.

Let me put this word in. I do not want to be too critical, but I have had a small, very small responsibility in the classroom; and, frankly, during the time that these boys were in the service and getting money in their pockets, the quality of the work which they did was much lower than it was when they were hitting it hard to make a go of it there in school. I think they need a bit of that in order to really make them realize what they are working toward. We are getting things a little too easy for us.

If and when these have failed, then and only then will we be justified in resorting to ideological experiments.

If, after proper study and fair trial of other more acceptable means of providing service, the Congress in its wisdom decides that we must completely abandon present practices and adopt new methods of procedure, extensive organization will be necessary to implement the program.

The framework of such an organization now exists in our State and local health services. We have the greatest collection of talent in public health administration to be found in the United States. We have had extensive experience in the control of communicable diseases. We are gaining experience in the administration of chronic-disease programs and hospital programs. As an organization, we have the respect and confidence of the public and the cooperation of the private practitioners of medicine. We are all good citizens and, regardless of the outcome of this or similar legislation at present or in the future, we shall continue to work for the best interests of the people, and to the extent of our ability we will carry out the mandate of the Congress.

In closing, permit me to say for our association and for myself, personally, that we apreciate being invited to appear before your committee to present our views on the legislation under question.

Thank you.

Senator MURRAY. Doctor, I notice you state: "If, after proper study and a fair trial of other more acceptable means of providing service, the Congress in its wisdom decides that we must completely abandon present practices and adopt new methods of procedure"—now you do not assume that 1679 proposes to completely abandon present practices and adopt new methods of procedure; do you?

Dr. HUTCHESON. Not 1679 in itself; no, sir. I am talking about the whole general trend toward the reorganization of the entire field of medical education, dental education, nursing, medical practices, scientific research, and everything.

Senator MURRAY. That statement is not intended as a reflection on 1679.

Dr. HUTCHESON. No; it is a general statement in closing.

Senator MURRAY. Because 1679 proposes to do all of the things that you are recommending with reference to stimulating medical education, training of personnel.

Dr. HUTCHESON. We are very much for that.

Senator MURRAY. The only part of our bill that you take issue with is the one providing for the insurance system.

Dr. HUTCHESON. Compulsory health-insurance system or voluntary. We are against both voluntary and compulsory right now; that is, legally stimulated voluntary insurance.

Senator MURRAY. I see. You see no difference between a compulsory system, such as we propose, and a compulsory system of voluntary insurance?

Dr. HUTCHESON. I do not see a great deal of difference in it. I would like to say this, though, in closing, if I may.

We have a young man down in our State by the name of Cash who made a study. He lives in a rural county, Wilson County, Tenn.

He made a study of the cost of medical care. He used the school teachers, who are average-paid individuals, to determine what they had paid during the past 12-month period for medical care in that county, a limited area. It was, I think, in the neighborhood of $12. Then he asked them had they gotten everything they wanted, and in the majority of instances the answer was "Yes."

Now he then computed the cost to that teacher in deductions from salary based on 3 percent, I think it was, which ran, of course, five or six times the total that it actually cost them.

Senator MURRAY. Of course, in this country there are many people in favorable positions and favorable occupations.

Dr. Hutcheson. Well, I do not think school teachers are in too favorable positions in Tennessee. They are working 8 months out of the year, and their total income is around, I imagine, between $1,600 and $1,800.

Senator Murray. But they are at least in a better position than those men who have to go down 5,000 feet below the surface of the earth to work in the mines where they have these dust conditions, and so forth.

Dr. Hutcheson. Yes; they probably are in much better condition.

Senator Murray. And, of course, we have employees in this country, something like 60,000,000 workers, and they are employed in all sorts of occupations, many of them extremely dangerous.

Dr. Hutcheson. True, but this boy took that simply because he though they were about the average, and he was looking for an average figure.

Senator Murray. Of course, there are many of us that never have to go to a doctor at all. Senator Taft, for instance, is a man of great health. He is the sponsor of this bill. He never has spent a dollar on a doctor. Senator Donnell is in the same situation.

Dr. Hutcheson. Well, he is lucky.

Senator Murray. That is the reason they are conservative about this.

Senator Donnell. Senator Murray did not have any occasion to go to the doctor during the time he held that policy, and when he got to 65 they canceled the policy.

Doctor, I would like to ask you a few questions. You say at page 5 of your prepared statement that the association—that is to say, the State and Territorial Health Officers Association—is opposed to the principle of compulsory health insurance.

Senator Murray calls your attention to the language also on page 6 of your statement:

> If after proper study and a fair trial of other more acceptable means of providing the service that Congress in its wisdom decides that we must completely abandon present practices and adopt new methods of procedure, extension of organization will be necessary to implement the program.

Now S. 1679 does adopt compulsory health insurance; does it not?

Dr. Hutcheson. The bill does; yes.

Senator Donnell. So that, in regard to that portion of the bill—that is to say, title VII, I believe it is—which contains the provisions for compulsory health insurance, there is the complete abandonment of present practices and the necessity of adopting new methods of procedure. That is correct; is it not?

Senator Murray. Well, let me interrupt there for a minute. It does not propose anything of the kind. It just proposes a method of paying for medical care, but it doesn't change the practice of medicine in any particular.

Senator Donnell. I am not taking about the practice of medicine. I am talking about the practice with respect to the provision of insurance. Today we do not have any compulsory medical insurance. That is correct; is it not?

Dr. Hutcheson. That is right.

Senator Donnell. And under S. 1679 we would establish it. That is correct; is it not?

Dr. Hutcheson. That is the way I understand it.

Senator DONNELL. And extensive organization would be necessary to implement the program of that compulsory health insurance. That is right; is it not?

Dr. HUTCHESON. Very extensive, surely.

Senator DONNELL. Doctor, how long has your association been opposed to the principle of compulsory health insurance?

Dr. HUTCHESON. The association has not until just recently taken any positive stand on it, because, as I have said in here, we have always been primarily interested in the prevention of disease rather than in the treatment of disease.

We were invited—now I do not know just how the invitation came about—to give testimony before the committee on this, and when I got the letter it occurred to me that we had to make a decision. We had to come out and say one way or the other where our stand is; and, as a result of that, I got the committee together, the executive committee of the association.

We went over the bills in detail, and I prepared this statement and mailed it to every single member of the State and Territorial Health Officers Association, saying that that was the attitude that the committee had taken and we wanted to know whether or not it was the attitude of the individual members, to please let me know if they did not approve. I have had no single individual who has disapproved of the statement that I have presented.

Senator DONNELL. How many members do you have?

Dr. HUTCHESON. In number who have——

Senator DONNELL. Who have affirmatively approved it.

Dr. HUTCHESON. Very affirmatively. They said they thought we should have done it a good while ago. The total membership representing the official State officers of the various States and Territories, and the directors of the programs, hospital construction, and mental hygiene that are not in some of the States operated by the State hospitals total, I believe, 78. The personnel employed in those organizations that are represented by those health officers and the various associations that work with them in numbers is rather considerable. I could not say just how many. In my own State, though, it is over 1,200, and we are about an average rural State.

Senator DONNELL. Doctor, how large an executive committee does the association have?

Dr. HUTCHESON. We have four members besides the officers. The total would be seven.

Senator DONNELL. And when and where did that executive committee meet?

Dr. HUTCHESON. We met at my request here because it was more central. Dr. Halverson, of California, was not present, but we did send to him the minutes of the meeting, and he approved them.

Senator DONNELL. When did you meet here in Washington?

Dr. HUTCHESON. About 2 or 3 weeks ago.

Senator DONNELL. And you formulated your views. Was there any dissent?

Dr. HUTCHESON. No; there was no dissent. Actually, Senator, it was not a question of formulating the ideas, but getting an official statement. We have talked this thing over for years.

Senator DONNELL. So you really arrived at a decision?

Dr. HUTCHESON. An official decision.

Senator DONNELL. It was a matter of formulating officially that expression.

Dr. HUTCHESON. That is right, sir.

Senator DONNELL. And there was no dissent in this executive committee in Washington held 2 or 3 weeks ago on the proposition that the association is opposed to the principle of compulsory health insurance.

Dr. HUTCHESON. Not at all.

Senator DONNELL. Then you prepared the statement which you have presented this morning and mailed it out to these approximately 78 members?

Dr. HUTCHESON. Every single one of them.

Senator DONNELL. And you requested anybody that objected to it to let you know, and nobody has objected so far?

Dr. HUTCHESON. To let me know by wire. I have gotten letters from a number, and I have gotten wires from several, not in the negative but in the affirmative, congratulating the committee on its action and saying, "We are glad you have taken a positive stand on this thing."

Senator DONNELL. In other words, in response to your sending them a copy of this statement which you have this morning delivered, you have received no expressions of disapproval of that statement, and you have received a number of affirmative expressions of approval, some of which even go further than a mere expression of approval, but indicate that the association should have gone further some time ago, is that right?

Dr. HUTCHESON. That is correct, sir.

Senator DONNELL. I see you are bringing over that bag. Were you going to produce a letter or two there?

Dr. HUTCHESON. I have one that I got just as I was leaving, and I stuck it in my pocket. I was going to show it to you.

Senator DONNELL. Would you mind letting me see it? While you are looking for it, Doctor, could you tell us about when it was you sent out this statement with a request for telegraphic expressions from anyone who disapproved of it?

Dr. HUTCHESON. I think it was Wednesday a week ago.

Senator DONNELL. In other words, there has been plenty of time for you to get answers back?

Dr. HUTCHESON. Yes; I have letters from a friend of mine out in Arizona.

Senator DONNELL. Have you got anything from anybody out as far as Montana?

Dr. HUTCHESON. No, sir; I do not remember.

Senator MURRAY. We have got them better trained out there.

Dr. HUTCHESON. Senator, I am afraid that I did not bring the letter with me. I thought I did, but I probably left it in my pocket.

Senator DONNELL. Doctor, would you mind just telling us why in your opinion the association is opposed to the principle of compulsory health insurance? What is the fundamental basis of your opposition to it, if there is anything you can add to what you have already given?

Dr. HUTCHESON. I think that I have covered it about as completely as I possibly could have, Senator. I would be glad to elaborate on it.

Senator DONNELL. I would like to have you elaborate to this extent, if you have any information along this line. You referred to the fact that over a period of years your department has had visitors from almost all countries in the world. I believe that was the substance of what you said.

Dr. HUTCHESON. Yes, sir.

Senator DONNELL. Have you derived any information from other nations through the medium of these visitors or otherwise which would enable you to give their opinion as to how similar plans have fared elsewhere?

Dr. HUTCHESON. I can speak only personally because I have not taken it up with the association, but I can give you some very definite opinions that have been expressed by certain individuals.

Senator DONNELL. Will you be kind enough to give us your observations that you received?

Dr. HUTCHESON. The one that I have seen that was pleasing—I would say the one that I have seen that was pleasing was the Highland and Island Service of Scotland. I do not mean that I saw it, but the individual who had worked in it, and he described it to me, and in that service—are you familiar with it?

Senator MURRAY. This is in Scotland that you are talking about?

Dr. HUTCHESON. Scotland, the Highland and Island Service.

Senator DONNELL. I do not want to parade under any false colors. I am not familiar with it.

Dr. HUTCHESON. Briefly, it is this: A boy graduates from medical school, and he is given a choice, as a reward for work well done in school, of the area to which he will go as an externship. He goes in there and he takes care of the various sparsely settled areas of all of the medical and public health needs.

He is furnished a house, a carriage, or a motorboat, or whatever means of transportation can be used in the area, everything that he needs with which to practice, a nurse, and he is guaranteed a certain income, which, at the time I discussed it with Dr. McPhearson, was, I think, £500. He collects what he can, and he must keep an accurate set of books on his collections.

The fees that he collects are fixed, and at the end of the year what he has failed to collect is made up. He can have this position only 2 years, and then he must move on, or go on his own. The guaranty is for only 2 years.

Senator DONNELL. Who issues the guaranty?

Dr. HUTCHESON. The Government. If he likes to stay, O. K. If he wants to go on, O. K.

They consider it, or this boy did, at least, an excellent period of training, equal, he said, to the hospital, and in some instances was needed to polish off his experience which he got in the hospital, and sometimes he became "hospitalized," as we call it, and then out in the rugged area he got rid of some of that and began to balance his work, clinical with the scientific.

Now, he liked it. That is the only one I have heard of where the doctor himself told me frankly, "Well, by golly, we like it."

Senator MURRAY. What is that? I did not hear your last remark.

Dr. HUTCHESON. I say that is the only one that has been represented to me by a doctor working under plans in the various countries where they said they liked it.

Wait a minute; that is not true, either. Dr. Locheck, of Czechoslovakia, before the war was very enthusiastic about it; but——

Senator DONNELL. Doctor, would you mind telling us what the observations, generally speaking, have been of the others, other than this one?

Dr. HUTCHESON. The observations generally speaking are that the person on the panel practice gets a low class of medical service and gets his symptoms treated rather than his disease.

Senator DONNELL. That is what you have been informed by the observations from these various countries?

Dr. HUTCHESON. That is right.

Senator DONNELL. Other than this one from Scotland and Dr. Locheck from Czechoslovakia, and you are not vouching——

Dr. HUTCHESON. I was not able to get a positive statement out of Dr. Alexander Robakin from Russia. Before this country recognized the Russian Government, he was a guest of the Rockefeller Foundation, and the State Department asked to arrange for an itinerary for him, and he came down and spent a month with us. He was for the work, and he very emphatically stated that he did believe that it was a good type of service, but he said, "We still have some private practice."

Senator MURRAY. Doctor, you just said that your understanding was that these doctors in these other countries where they have these different symptoms are treating symptoms instead of disease. Is that not your language?

Dr. HUTCHESON. Yes, sir.

Senator MURRAY. Well, that is exactly the situation that you described here a little while ago.

Dr. HUTCHESON. I know it.

Senator MURRAY. As being practiced in the United States.

Dr. HUTCHESON. I know, but there is this difference. The doctor himself has seen the patient, and if he seems to think that the patient really is in critical need, he is treated. Actually, Senator, if 80 percent of the people did not go to the doctor, they would be just as well off. They do not need anything, and would get well just as quickly.

Now here is what happens. A person has got a panel practice, and he has got an office over here on one side and another office over here. The panel practice goes in here, his private cases go in here, and he comes in. The nurse says, "How are you feeling this morning?" "I have got a headache." "Well, take an aspirin."

Senator DONNELL. This is the panel practice?

Dr. HUTCHESON. Yes. The doctor goes over here and he sees this patient and gives all the time he needs to give to the patient, and the nurse sees this one over here.

Senator MURRAY. Where is this practiced?

Dr. HUTCHESON. That is being done in England today.

Senator MURRAY. Right now at the present time?

Dr. HUTCHESON. Yes, sir.

Senator MURRAY. Where did you get this information.

Dr. HUTCHESON. From some English physicians.

Senator MURRAY. When did you get it?

Dr. HUTCHESON. Within the last 3 weeks.

Senator MURRAY. English physicians traveling in this country?

Dr. HUTCHESON. Yes, sir.

Senator MURRAY. Of course you have read that there are many English physicians that are highly recommending the system?

Dr. HUTCHESON. Absolutely, I know it.

Senator MURRAY. Did you contact any of the people over in England?

Dr. HUTCHESON. No; I have not been there, Senator. The only ones I have talked to, of course, are people in my profession.

Senator DONNELL. These English physicians that are traveling in this country that you talked with, did they express the view that adequate efficient care is being given at this time in England under the system that is now in operation?

Dr. HUTCHESON. No. They expressed this view, though, which this committee should have. They said that a majority of the physicians in England who had some difficult time financially really liked it.

Senator DONNELL. I want to know particularly of the character of service that is being given to the public.

Dr. HUTCHESON. They thought that there was not the character of service being given that had been given in the past.

Senator DONNELL. And did they feel that there was a tendency in England to have great numbers of people crowding in to get service and that the physicians just did not have enough time to give it?

Dr. HUTCHESON. Well, they said there are many more. The people that I talked to—and I think it is important to get the slant—were not necessarily in school, but men of professional status that were more inclined to look on the thing as to what it was going to mean in the training.

Senator DONNELL. What did they say that they thought was going to result?

Dr. HUTCHESON. They were not satisfied with it, Senator. They thought that there was grave danger of the deterioration of the class of medical practice. That was the general consensus.

Senator DONNELL. Now, Doctor, I do not want you to violate any confidence, and I am not asking you to do that. If you care to give us these names, you may. If you do not, you do not have to.

Dr. HUTCHESON. I would not like to unless you order me to do it.

Senator DONNELL. I am not doing that. If you feel you would violate any propriety, I certainly will not ask you for names.

Senator MURRAY. Doctor, right there you will concede, I am sure, that this testimony you are giving is largely hearsay. It is entirely hearsay.

Dr. HUTCHESON. Most of what I have said is.

Senator MURRAY. Which would not be accepted in any court in the country.

Dr. HUTCHESON. No, sir. I would not have tried to present it to a court.

Senator MURRAY. No; you would not think of it.

Senator DONNELL. This is not a court which we are operating here.

Senator MURRAY. No; but we ought to have some sense of propriety and not accept the generalities and conclusions and statements made by people who might have been hostile to the whole program, and yet on the other hand if you examine the situation in the field right in England, you might find a totally different attitude toward it. Is that not true?

Dr. Hutcheson. I could not say without examining it myself. The information that I have got is satisfactory to me.

Senator Murray. Some one or two individuals told you this, and you accept that?

Dr. Hutcheson. I have talked not to one but several in this country who personally paid their own expenses over there to see what was going on.

Senator Murray. Did you read any statements made by people who went over there and came back and told them entirely different stories?

Dr. Hutcheson. Yes, sir.

Senator Murray. You have, and you have seen statements issued, for instance——

Dr. Hutcheson. Not of men, Senator, that I really think are capable of judging it.

Senator Murray. Have you read any articles coming out of Great Britain and the British press?

Dr. Hutcheson. I have read articles in our own press here and in magazines on it; yes.

Senator Murray. Well, the Lancet, for instance, is a well-known publication over there recognized as a very importnt medical paper. Is that not true?

Dr. Hutcheson. Yes.

Senator Murray. Have you read any statements appearing in the Lancet?

Dr. Hutcheson. I have read excerpts from it. I do not want to say too much about the British. It is not British alone.

I say this; that this information that I have got indicates that there are great numbers of physicians who were not doing financially too well who are for it, very much for it, and that in itself seems to me to be an argument against it.

Senator Murray. Well, of course, that is the situation in this country. Those doctors who are doing extremely well in this country would be against it. For instance, there is some evidence that has been produced here that some of them made as much as $186,000 net.

Senator Donnell. Was that net or gross, Senator?

Senator Murray. No; it was net. It was an income-tax case, so they do not pay on their gross income. They pay on their net income. If I belonged to a profession, an industry, or business of any kind, that netted me a splendid income like that——

Dr. Hutcheson. From his practice or his total income?

Senator Murray. This is his practice.

Dr. Hutcheson. His medical practice alone?

Senator Murray. Yes; medical practice. He is an expert.

Dr. Hutcheson. Of course, he is doing a great deal more——

Senator Murray. Do you not believe there are high incomes of that kind in the medical profession in the United States?

Dr. Hutcheson. Not in my State.

Senator Murray. Well, I am not talking about your State, but I am talking about some——

Dr. Hutcheson. I think they would be extremely rare, more rare certainly than in the legal profession.

Senator Murray. Well, anyway, these doctors that you met in this country who have traveled around the country, and you showed them what we are doing in this country under the Public Health Service, they approved the socialized medicine practiced by the Public Health Service, did they not?

Dr. HUTCHESON. I did not understand you, sir.

Senator MURRAY. Well, did they not approve the kind of medicine that the Public Health Service is giving to the people of the country?

Dr. HUTCHESON. Preventive medical service; yes, sir; I think so.

Senator MURRAY. And that is a socialized program?

Dr. HUTCHESON. To a certain extent; yes.

Senator MURRAY. Thank you, Doctor.

Senator DONNELL. Doctor, you have heard of the Right Honorable Aneurin Bevin, Member of Parliament, Minister of Health in England. I would like the record to show at this point this one paragraph from the record of proceedings at the first annual meeting of the Executive Council's Association held in the Great Hall, British Medical Association House, on the 7th and 8th of October 1948. This is a paragraph from a statement of the Right Honorable Aneurin Bevin, M. P., Minister of Health.

Senator MURRAY. By him?

Senator DONNELL. Yes. It says:

> Now, the executive council, because it is the administrative body responsible for the general practitioners' service and for the ophthalmic opticians and dentists and chemists, has a very important function to perform in raising and retaining the highest standards of educational conduct among these professions. I have been exhorting the general public in the last few weeks to make use of this national health service prudently, intelligently, and morally, because if too great a strain is placed upon it at the beginning it might break down, and because things are free is no reason why people should abuse their opportunity. This is a very great test of the maturity of the British people—that we put at their disposal, insofar as they are available, all the resources of the medical profession without charge, and if the people abuse it, if those who do not really need it demand it, then they will be merely standing in the way of those who need it more. And so we should, in all our separate places, with all the contacts that we have at our disposal, exhort the people to use this thing as though it were their own—because it is in fact their own—and that when any individual abuses it he must reckon with the sum total of abuse which might add up to a sum very grievous to carry and very difficult to continue to provide.

Doctor, I would like to ask you whether or not you learned from these English anything as to their impression as to whether the people are following that admonition or whether they are going in and asking for services for the slightest trivial condition that exists in their health.

Dr. HUTCHESON. I got the general impression—of course, I had not read that paragraph—that the total demand for service had markedly increased and that the Government had markedly underestimated the cost of it.

Senator MURRAY. Well, would that not necessarily happen, Doctor, when you come to consider that prior to the introduction of this system many of them were getting no medical care whatsoever, dental care or eye care?

Dr. HUTCHESON. No, Senator. I think most of it is not due to that. I think it comes about because it is a free service. They have got it and if they stub their toe, instead of wrapping it up and putting whatever they like on it, minor superficial injuries and ill-defined complaints that probably are not complaints at all are being carried to the physician, and his time is being burdened with them to a far greater extent than was true before this thing went into effect, and to an extent which makes it practically impossible for him to really do the job that he is supposed to do.

Senator MURRAY. Well, you are making a very comprehensive statement here with reference to what the situation is in England.

Dr. HUTCHESON. No; I am talking about what would happen here, not in England. I am talking about the whole world. That is human nature. You know human nature. A man of your caliber is bound to know it, and you know what they will do.

Senator MURRAY. Do you mean to say that you know exactly what the people in England are doing with reference to seeking medical care?

Dr. HUTCHESON. Not exactly; no, sir.

Senator MURRAY. Do you think, if an Englishman had a perfectly good set of teeth, that he would go down and try to get a false set of teeth for nothing because he would be getting it for nothing?

Dr. HUTCHESON. Certainly not, sir.

Senator MURRAY. Or a cork leg when he did not need it?

Dr. HUTCHESON. Certainly not, but I do know that a great many people will go to a doctor——

Senator MURRAY. When they think there is something wrong. That is the thing you are trying to encourage in this country.

Dr. HUTCHESON. When there is not service for them. I mean there is not personnel and numbers sufficient to provide the service. If we had plenty of people, I think it would be a fine thing for as many people to go as thought they needed it, but there ought to be a middle ground somewhere that we could reach where the men could have more time to give very serious study to the critical need of the patient who is acutely ill and really needs his service.

Senator MURRAY. Thank you, Doctor.

The next witness will be Dr. Hugh R. Leavell. You are from Boston, Doctor?

STATEMENT OF HUGH R. LEAVELL, M. D., PROFESSOR OF PUBLIC HEALTH PRACTICE, HARVARD SCHOOL OF PUBLIC HEALTH, AND CHAIRMAN OF THE EXECUTIVE BOARD, AMERICAN PUBLIC HEALTH ASSOCIATION, NEW YORK, N. Y.

Dr. LEAVELL. Yes, sir. I had my college work in Virginia, and I graduated from Harvard Medical School and got my doctor of public Health at Yale. I have practiced in the Massachusetts General Hospital, the Presbyterian Hospital in New York, and Johns Hopkins Hospital.

I had about 7 years of private practice, was the health officer of Louisville and Jefferson County, where we were responsible for the medical care as well as the public health activities, all tax-supported activities in the community.

I taught in the medical school there, and I am now teaching public-health practice at the Harvard School of Public Health. During the war I was in the Public Health Service, worked in the European regional office of UNRRA. I spent a year in the division of medical sciences of the Rockefeller Foundation. During the past summer I represented Public Health on medical activities task force of the

Hoover Commission. I have had some experience in England and the Scandinavian countries both during the war and in the summer of 1947.

In seeking to find out how the plan was working in England, I went back this past February to get a personal check-up on what was going on there.

Senator MURRAY. This last February?

Dr. LEAVELL. February 1949. I am representing the American Public Health Association as chairman of the executive board. The association is most grateful to the chairman and members of this committee for the opportunity of presenting our testimony on the bills under discussion.

In 1944, the governing council of the American Public Health Association adopted an official statement of policy relating to medical care in a national health program. Other statements have since been adopted consistent with the one made in 1944. The American Hospital Association, the American Medical Association, and the American Public Welfare Association cooperated with the APHA in a joint statement on planning for the chronically ill in 1947, and the American Hospital Association joined with the APHA in a statement on coordination of hospitals and health departments in 1948. The subcommittee on medical care of the APHA will shortly publish a statement on the quality of medical care in a national health program which will discuss in some detail many features of this most important quality factor. This subcommittee as well as the APHA itself is continuing efforts to view the whole problem of medical care from the broadest possible standpoint and to seek out areas of agreement among professional and other groups concerned with the problem. The APHA has a large and vigorous special section devoted to discussions of medical care. A large proportion of our membership of some 11,000 are health officers legally entrusted with the duty of devising methods to improve the health of the public. This legal responsibility for the health of the people is probably not true to an equal degree of any other professional association in this country.

We, therefore, feel not only the right but the responsibility to express our opinion regarding measures under discussion before this committee. Because our membership is especially concerned with administrative problems, we shall devote special attention to such problems as they may be involved in implementing the various programs proposed.

While proud of the advances made in public health and medicine which have given the American people an enviable position in these fields, we are not content with the present situation and can see much room for improvement. Our 1944 statement points out the major needs as follows:

1. "A large portion of the population receives insufficient and inadequate medical care" due to inability to pay costs of services on an individual basis when they are needed or because services are not available. Distribution of costs is proposed as an important remedy for this need.

2. "There are extensive deficiencies in physical facilities needed to provide adequate services," especially in poor communities and rural areas. The construction of health centers, hospitals, and group-prac-

tice facilities will supply the needed buildings, but maintenance is already a problem in many areas.

3. "There are extensive deficiencies in the number and the distribution of persons needed to provide the services" and to administer them. Training of personnel is proposed as an important remedy for this need; special inducements will also be required to improve the distribution.

4. "Expansion of scientific research is urgently needed." Financial assistance from the Government will be required to provide funds to make this research possible.

The 1944 statement also set forth certain major objectives: (1) to make available to the entire population all essential preventive, diagnostic, and curative services—people must not be separated from medical care for economic reasons; (2) to insure that services are of highest standard and rendered under conditions satisfactory both to the public and to the professions; (3) to extend scientific knowledge and provide for constant evaluation of the program.

We think of a national health program as something which belongs to all the people and to which all groups with special skills contribute as they are able; no program could be truly national in the American sense if it did less. We consider it highly important for all concerned—professions, the general public, and the legislators representative of both groups—to think of the health problem as a broad one. Therefore, we welcome the comprehensive approach found in legislation presently under discussion. Piecemeal legislation and attacks on categories of disease are of value, but efforts to put the pieces together into a broad, inclusive program will undoubtedly be much more productive.

The conception of a broad plan obviously does not imply that all its aspects are of equal importance at any given moment. Our 1944 statement says:

> Because of inadequacies in personnel and facilities, this goal (a national plan should aim to provide comprehensive services for all the people in all areas of the country) cannot be achieved at once, but it should be attained within 10 years.

Training for personnel must be provided, health facilities constructed, local public-health units strengthened and extended to all areas, methods of paying for services and for equalizing financial burdens must be applied and research supported. Some priority system is needed to determine where major emphasis should be placed from time to time. People are prepared to wait for worthwhile aims if they can see that steady progress is being made and that there is an over-all plan reasonably calculated to ultimately reach the goal.

The American Public Health Association believes that the Congress would be materially assisted in its deliberations on the national health program if major groups representing those providing and administering services met with consumers of health services and reached agreement on a system of priorities. The APHA has invited the American Health Association, the American Medical Association, and the American Public Welfare Association to join in sponsoring a conference to which other professional organizations concerned would be invited as well as management, labor, farmers, and other consumer groups. There is real hope that such a conference may be useful in helping the Nation find needed answers to problems of health and medical care which are so important at the present time.

My plan, Senator, is to take certain general aspects of the problem as we see it and try to apply that to various bills under consideration and see how they conform with the things which we have stated we feel are important.

Preventive Services:

Our 1944 statement, recommendation 1 (*b*) says:

> It is imperative that the plan include and emphasize the provision of preventative services for the whole population—

and the statement on quality of medical care referred to above elaborates this idea as follows:

> A most significant criterion of high quality medical care is the degree of emphasis placed upon prevention of disease. The unfortunate separation of preventive and curative medicine * * * is incompatible with the highest standards of modern medicine * * *.
>
> A national health program must include provisions for the development of full public health coverage in every area and must also integrate its medical services with the activities of public health agencies.

We feel this problem of integration is of very great importance.

The very great importance of Federal assistance in the development of local public health units has been stressed during hearings on S. 522. There are many phases of preventive medicine which should form an integral part of the physician's practice. Early diagnosis and prompt, adequate treatment of disease followed by suitable rehabilitative measures are quite obviously preventive in nature.

It might be pointed out that there are many other aspects of preventive services which the physician in practice can quite logically and most effectively give to his patients. The prenatal care of expectant mothers, the conduct of child health services, and so on. The survey recently made by the Academy of Pediatrics demonstrates much of child care is rendered by general practitioners. That can be expanded materially; also the provision of immunization, the provision for periodic examinations to detect disease in early stages and have them treated.

I think it is important to bear in mind that to provide this type of preventive service the physician will not only need his intensive desire to do the best for his patient but some financial incentive, and we feel that in some instances that is not provided in the bills under discussion.

S. 1456 and S. 1581 should help to make medical care available earlier in illness to the lowest income group. Insofar as these bills would operate through voluntary prepayment plans as now constituted, there would, however, probably be little emphasis on preventive services since most of the plans now available are devoted almost exclusively to the diagnosis and treatment of certain types of illness for a limited period and in a limited amount.

S. 1679 does take into account the importance of providing preventive services. I am speaking about practicing physicians now providing those services now, but the mechanism by which this might be accomplished is not spelled out in detail. Unless some special provision is made, plans involving fee-for-service payment methods, permitted under S. 1679, are likely to result in a minimum of preventive services.

Administration by a single responsible agency:

The APHA 1944 statement, recommendation 2 (a) states that:

> A single responsible agency is a fundamental requisite to effective administration at all levels—Federal, State, and local. The public health agencies—Federal, State, and local—should carry major responsibilities in administering the health services of the future. Because of administrative experience, and the accustomed responsibility for a public trust, they are uniquely fitted among public agencies to assume larger responsibilities and to discharge their duties to the public with integrity and skill.

It is not implied that under no circumstances should a Government health program be administered by some agency other than the legally constituted health agency at all levels. However, opportunities for much needed coordination will be administratively simplified if all governmental programs in which health is the major item are administered by the health agency.

FEDERAL LEVEL

S. 1106 places administration in the Surgeon General. S. 1456 also makes the Surgeon General responsible and authorizes him to make necessary regulations subject to approval of the Federal Security Administrator and the Medical Care Council. S. 1581 sets up a new national health agency composed of units now in the Federal Security Agency concerned with health problems, specifying in some detail how the new agency shall be organized and providing for a completely new Office of Medical-Dental and Hospital Services completely separate from the Public Health Service without provision for participation by the Surgeon General. This radical reorganization plan fails to take into account recent recommendations of the Commission on Organization of the Executive Branch of the Government. If reorganization of Federal agencies is to take place, it should be carried to its logical conclusion and not done piecemeal. S. 1679 provides for a national health insurance board to administer title VII with the Surgeon General and the Commissioner for Social Security as members. It would be preferable for the administration of health services under this bill to be placed in the Public Health Service which is responsible for preventive and other curative health services.

That is, providing, of course, the Hoover Commission's recommendations were not put into effect and a complete new united medical association set up, as was recommended by the Hoover Commission.

The Public Health Service has a long record of effective administration of health programs and is ideally fitted to achieve close coordination of preventive and curative services. As you are undoubtedly aware, the Hoover Commission's recommendation was for a united medical administration with three branches—one a preventive branch, one a research and training branch, and the other a medical-care branch with a fourth sort of arrangement for administrative services, finance, and personnel.

STATE LEVEL

A single administrative agency at the State level is probably of even greater importance than in the Federal Government.

S. 1106 provides for the State health agency to administer the plan.

S. 1456 provides for (a)—

> Single State agency (which may be the State agency designated to administer part C of the Hospital Survey and Construction Act in such State) as the sole agency for the administration of the State plan.

While a majority of the States have designated the State health agency to administer the Hospital Survey and Construction Act, a number have not done so. There would be serious administrative weakness in extending this separation of health administration.

S. 1581 designates the State health agency as the sole agency for the survey to be made under title II—section 202 (a) (1)—and makes the rather wise provision—section 212 (a) (1) to—

> designate the State health agency as the soleagency for the administration of the plan or for supervising the administration of the plan: *Provided*, That nothing in this part shall be construed as prohibiting a State plan from providing such administrative arrangements involving other State agencies as may be necessary to prevent duplication of existing administrative functions.

This language is probably the best found in any of the bills under discussion for handling this problem.

S. 1679 states that administration of title VII should be a State responsibility to be discharged in each State, insofar as feasible, by the same State agency which administers, or supervises the administration of, the State's general public-health and maternal and child-health programs, and further specifies that the agency be designated as the sole agency for the State-wide administration of benefits under this title. The language of S. 1581 seems preferable on this point.

LOCAL LEVEL

Perhaps there is no other more important level than the local level. I speak as a former local health officer. We feel that the State and Federal Government in the health fields are simply there to make it possible for the local man to do the job.

Methods of local administration are not specified in either S. 1106 or S. 1581. There is some ambiguity in S. 1456, which specifies that the plan proposed would be "in effect in all political subdivisions of the States and if administered by them be mandatory upon them" (sec. 713 (a) (1)).

A hospital and medical care authority would be created for each region—section 713 (a) (11)—to encourage coordination of all health facilities and services within the region and to cooperate with and assist the State agency in carrying out the State plan; but the method of appointment is not stated. "The appropriate agency or agencies" would certify persons as unable to pay and issue service cards to them. Great possibilities for administrative confusion at the local level would be likely unless there is clearer definition of responsibilities.

S. 1679 provides for States to decide whether local administration shall be carried on by an administrative officer or by a committee with an executive officer. The admissibility of permitting administrative committees as S. 1679 does is highly questionable. Appointment of the local administrator or committee would be by the State agency, that is to say, the State plans provide that the State in making the plan will set up how these local agencies are to be appointed. It would conceivably be quite possible that the State might make all of the appointments itself.

No provision is made for local participation in these appointments. It is quite true that the States could make provision for such local participation in their plans, but there is nothing in the bill that would require them to do that.

Senator MURRAY. You think there should be some requirement?

Dr. LEAVELL. I would think so, Senator; yes, sir. Otherwise the administrative responsibility would be entirely in the hands of the States. It probably would be more accurate to say it probably could be entirely in the hands of the State.

ADVISORY BODIES

The 1944 OPHA statement recommendation 3 (b) says:

> The agency authorized to administer such a program should have the advice and counsel of a body representing the professions, other sources of service and the recipients of service.

S. 1106 provides only for consultation with the conference of State health authorities which is perhaps all that would be necessary for a limited program. However, should large appropriations become available under this bill a more broadly representative group would be necessary.

S. 1456 establishes a Federal hospital and medical care council appointed by the Federal Security Administrator, 4 of the 10 appointed members representing consumers. This council would have powers of approving regulations prescribed by the Surgeon General and could override him on approval of a State plan which he had failed to approve.

In our testimony on S. 545 under the preceding Congress we made the following statement about this, which I should like to recall to you:

> The power of the National Medical Care Council to overrule the decisions of the Director in regard to approval of State plans or modifications thereof is contrary to sound administrative practice. It is inappropriate to give this body of part-time representatives veto power over administrative officials who are charged with carrying out the purposes of the bill.
>
> The Council should remain an advisory body. Otherwise the administration of public funds will be controlled by persons who are not responsible to the public and whose main allegiance may well be to the organizations and interests they represent rather than to the public welfare.

I return now to the prepared statement. Each State would set up a hospital and medical-care council, the method of appointment and duties of which are not specified. Each region to be established would have a hospital and medical-care authority; the method of appointment is not specified and duties are defined rather vaguely. Both State and regional bodies would have representation of consumers as well as providers of service. There would be real value in defining the functions of these bodies more clearly, spelling out whether they are administrative, advisory, or both. In general, they should be only advisory.

S. 1581 would set up a national medical- and dental-care council to be appointed by the proposed National Health Administrator. State medical, dental, and hospital-advisory councils would be appointed by governors; no stipulation requiring consumer representation is made in either case and both the Federal and State councils would be chiefly advisory. No provision for local advisory councils is made.

S. 1679 would provide advisory councils at Federal, State, and local levels with representatives "of the interests of individuals eligible for benefits" in the majority. Provision is also very wisely made for local professional advisory committees; such committees would be essential under any plan proposed. The wording of S. 1679 comes closer to representing the views of the APHA concerning advisory bodies than do the other bills under discussion.

LOCAL ADMINISTRATIVE AREAS

Members of the public will receive all services under any of the proposed measures in some local area, usually their place of residence. Therefore, it is of paramount importance to define these local areas with the greatest care so that all types of health service may be provided with the utmost efficiency and coordination. At present, hospital areas are designated in each State under the provisions of the Hospital Survey and Construction Act, with more or less attention to the promotion of a regional type of hospital organization. Each State has, in addition, local public-health areas usually laid out in accordance with local government boundaries. Frequently, there are additional and different districts for mental hospitals, tuberculosis hospitals, school health services, et cetera.

Regions established to administer medical care programs must take account of natural areas of trade and medical service. If proper regional organization of hospital and health center services is to be accomplished as is most desirable, these regions must be relatively large in area and population.

Currently, public-health services are provided for smaller population groups, the minimum for efficient and economical administration being about 50,000. As public-health programs for chronic disease become more effective, close working relationships with hospitals will be more and more important.

To provide for needed coordination between medical-care and public-health services, the administrative areas for each service must be planned to take account of the other. Federal legislation should take cognizance of this fact. In preparing their plans, States should be required to integrate medical-care administrative areas with local public-health jurisdictions. It would doubtless be desirable to include a number of local public-health areas within a single medical-care region but no single local public-health area should be divided so that its parts would be included in more than one region. Bills under discussion fail to make adequate provision on this point. S. 1106 does not mention local areas. S. 1456, section 713 (a) (11) provides for—

> regions in which the State has been or will be divided under the Hospital Survey and Construction Act, or by other means—

and indicates a recognition of the importance of avoiding another new and different set of regions. S. 1581 fails to mention the establishment of local administrative areas. S. 1679, title VII, part E, section 742 (a) (3) requires for approval of a State plan that it—

> provides for the decentralized administration of this title in the State in accordance with part D for the designation of local health-service areas.

ADMINISTRATIVE PERSONNEL

The 1944 APHA recommendation 7 (a) says:

> Education and training of administrative personnel should be encouraged financially and technically, especially for those who may serve as administrators of the medical-care program, for hospital and health-center administrators, and for nursing supervisors.

Only S. 1679, title VII, section 773 (a) (1), makes specific provision for the training of administrative personnel.

The success or failure of any of the plans under discussion will hinge to a considerable degree upon the availability of sufficient numbers of trained and experienced administrators of various kinds. The present supply is much too short to provide a number adequate for rapid expansion of existing programs. As a matter of fact, this shortage may prove one of the most important limiting factors in determining the rapidity with which broad new plans can be put into efficient operation. Grants to institutions providing this type of training, now available in a number of schools of public health, and fellowships for students are essential. It is also important that accompanying the training program there be such a pace of expansion of services as will provide suitable employment for trainees.

Just a word or two on that point. Obviously we cannot get people to take this training for medical care, administrators, unless there is an expanding field for them to work in, and some kind of coordinate planning is required to make those expanding fields available as the administrators become trained.

In order to make this part quite clear it is suggested that S. 1679, title I, section 372 (a) (4) be amended to read:

> To each school of public health which provides training leading to a graduate degree in fields relating to public health (including the administration of hospitals, clinics, and service programs.)

DETERMINATION OF ELIGIBILITY

The determination of eligibility for health-service benefits is a costly administrative procedure when it must be applied on an individual basis, requiring considerable personnel and frequently leading to embarrassment of applicants for benefits. When eligibility is universal, or when it can be determined by some very simple procedure such as the demonstration of membership in an insurance program there is essentially no problem or cost involved.

S. 1106 makes no provisions for determination of eligibility, but would provide expensive drugs, and so forth "free to such persons as may require them."

S. 1456 and S. 1581 provides health-service benefits for lower-income groups, and a means test would obviously be required to determine eligibility. The social implications of the means test are quite considerable, but they will not be discussed here. We do wish to call special attention to the administrative costs and difficulties.

I should like to again remind you of a statement made on S. 545 in the last Congress regarding the means test:

> Implicit in this language is application of the means test to determine those whose incomes are sufficiently low to be eligible. In actual practice only recipients of public assistance and those who are one step removed from public assistance could receive benefits under this bill. The average American citizen has

a deep abhorrence of the means test and of private and public charity. He will prefer to go deeply into debt, do without or dangerously delay needed medical services rather than submit to a financial investigation and accept charity medical care.

Senator DONNELL. Doctor, I did not understand from what you are reading.

Dr. LEAVELL. This was testimony which the APHA submitted under S. 545 in the Eightieth Congress.

Senator DONNELL. Is that testimony of Dr. Atwater?

Dr. LEAVELL. Dr. Atwater; yes, sir. [Reading:]

This is an important factor which will operate to limit the effectiveness of the proposed legislation.

Eligibility for benefits under S. 1679 would be tied in intimately with the existing social-security machinery and therefore a determination would be a very simple and exceedingly inexpensive process.

MERIT SYSTEM

All four of the bills under discussion make suitable provision for merit systems for State administrative personnel, which is most desirable.

VARIABLE MATCHING

The APHA 1944 statement, recommendation 2 (b) says:

The services should be financed on a Nation-wide basis in accordance with ability to pay with Federal and State participation and under conditions which will permit the Federal Government to equalize the burdens of cost among the States.

S. 1106 provides for a 50-percent Federal grant without taking into account the need for variable matching formulas. S. 1456 and S. 1581 provide for a sliding scale of Federal financing of 33⅓ to 75 percent based on per capita incomes in the various States. S. 1679 uses no formula under title VII but states:

Allotments shall operate to the maximum extent possible both to assure provision to eligible individuals of adequate personal health-service benefits in all States and all local health-service areas and also increase the adequacy of services where personnel and facilities are below the national average.

GROUP PRACTICE

There is quite general agreement that the group-practice system holds great promise of providing high quality of service at reasonable cost. Only S. 1679 makes provision for assistance in the establishment of new groups. There is recognition under this bill of the need for Federal funds to assist in the construction of group-practice facilities for cooperatives or other nonprofit associations. This is a principal bottleneck at the present time, limiting the extension of group practice. This bill also provides that payments for services may be made to groups of practitioners as well as to individual practitioners.

Recognition of group practice in prepayment plans and a certain amount of technical and financial assistance by Government in the establishment of group-practice facilities is justified.

Education and training of personnel for direct service. This is as distinguished from the administrative personnel.

There is little doubt that Federal financial assistance will be required to train personnel necessary in the national health program. Funds are needed to maintain existing instruction and to expand the instruction to larger groups of students. It would be most unfortunate to limit this training program to medical schools as is done in S. 1581, since other types of health personnel are in equal or even greater shortage at the present time. We shall not attempt to discuss the exact amount of Federal assistance which will be needed by the various types of schools. Unquestionably some degree of emergency assistance will be required even if it should be determined that a survey is needed to establish the financial needs of individual schools. The APHA is strongly in favor of Federal assistance to educational institutions and in the development of fellowships. There should be full recognition of the high costs of public-health education in relationship to some of the other kinds of training programs. Public-health training usually involves a concentrated and highly individualized course given within a single year to rather mature people who usually have family responsibilities and, therefore, require larger stipends to maintain themselves.

I might interject there also the comment that the public-health people cannot look forward to even a possibility of $184,000 income. The incomes that are available to public-health personnel are seriously limited at the present time, which is an additional reason for generous fellowships to students.

The principle of providing one sum as a subsidy for each student enrolled up to the average past enrollment and a larger sum for each student in excess of past enrollment is sound, we believe. In spite of what might appear at first sight to be a generous provision under title I of S. 1679 for the several categories of health personnel, it is our considered opinion that sums in excess of these amounts will be necessary to assure the success of the project. This opinion comes out of systematic reviews of courses which have been made by the association in connection with accreditation for graduate degrees in public health.

I might say that our association has assumed responsibility for accrediting schools of public health in this country and in Canada.

The Association of Schools of Public Health and other educational organizations involved will present their needs in detail at a later date.

We are of the opinion that appropriations for grants for construction and equipment in these educational institutions are sound in principle. We are persuaded that the number of those trained will not be substantially increased without funds for such a building program. Whether or not the universities will be able to match these Federal funds remains to be seen.

In general section 377, title I, of S. 1679, relating to scholarships, appears sound to the association.

The National Council on Education for Health Professions seems soundly planned. Schools of public health and engineering schools operate on a regional and national basis and it is completely unrealistic to regard them as State or local institutions. The training they conduct is for public service, and tax support is therefore entirely logical.

There is also need for the support of field training areas for public-health personnel. This need is entirely comparable to the necessity of hospitals for training physicians, and is equally worthy of support.

PRACTICAL NURSE TRAINING

S. 1679 takes account of the need for assistance in training practical nurses. This is a most important field requiring prompt development if we are to be able to staff our clinics, hospitals, and related institutions.

The association regards it as regrettable that practical-nurse training is placed in this bill under the Commissioner of Education of the Federal Security Administration, thus depriving the plan of the supervision available from the professional nursing staff of the United States Public Health Service.

It seems to us an unfortunate limitation that States can secure the benefits for practical-nurse training only for schools under public supervison or control. Just as in the case of professional nursing courses, some of the very best training is available under private supervision and control, and it does not seem that in the case of practical nursing these institutions should not be excluded from necessary assistance.

In the United States at the present time there are only about 70 schools of practical nursing approved by any authority, and these include a considerable number under private auspices. Most of these 70 institutions are not running to capacity. In spite of the importance of the training of more practical nurses it seems unlikely that a sum approaching $15,000,000 could wisely be used, especially if the beneficiaries are to be limited to institutions under public supervision or control. There is a sharp lack of adequately trained personnel to man the existing schools. There is, of course, a limit implied through the matching clause, page 37, lines 15–24.

The association approves the provisions for studies in this field which are badly needed and the advisory committee appears to be well set up.

Senator MURRAY. Will you excuse us for 2 or 3 minutes? We will take a short recess.

(A short recess was taken.)

Senator MURRAY. You may proceed.

Dr. LEAVELL. The association supports in principle the idea of Federal assistance to practical nursing. The objections to this section are, of course, minor in nature and less important than the principle of Federal aid.

MEDICAL RESEARCH

The need for an importance of medical and public-health research is recognized without question by the American Public Health Association, and strong support for this purpose is urged. The Commission on Organization of the Executive Branch of the Government in the report on medical activities says:

> The necessity for medical care, which requires heavy expenditures and much personnel, must not be permitted to result in minimizing the even greater importance of controlling disease. Research must be stimulated and supported to the extent which may prove necessary, to the maximum potential of the skilled manpower available to conduct it.

The association stands solidly behind the idea of the provision of funds for research, both of the conventional type of medical research and, very importantly, of administrative research as well.

That goes back to our statement concerning evaluation. We feel that funds should be made available so that any kind of program which the Congress decides upon can be constantly studied and evaluated, that existing programs be subjected to the same type of scrutiny. It has, I think, been the tendency among medical people as well as others to regard administrative research as perhaps of somewhat secondary importance to so-called basic medical research. It is our feeling that it is of certainly equal importance and requires strong support.

The seven specified diseases, this is in 1679, namely, poliomyelitis, diabetes, arthritis, rheumatism, multiple sclerosis, cerebral palsy, and epilepsy represent very diverse conditions of differing importance, some of which have reasonably adequate provisions already made for research into the cause, prevention, and methods of diagnosis and treatment, whereas others represent untilled ground. Presumably the phrase "and other disease or groups of diseases" would be effective in generalizing these provisions for research.

It would appear doubtful in the judgment of the association whether separate institutes to conduct and support scientific research and professional training in these several diseases would represent the best steps to be taken. This would permit pressures to be brought to bear on the Surgeon General in such a way that it would be difficult for him to be entirely objective about needed new institutes. The indefinite increase of national advisory councils would appear questionable in view of the established sectional committees under the research grants division of the National Institutes of Health. The National Advisory Council is now well set up and is capably performing an over-all function with reference to medical and public health research.

I might interject here the idea that the Hoover Commission task force has about these various councils. It was our feeling that the National Advisory Council should be an over-all body to which the other councils, such as heart and cancer, whatever it might be, would be subsidiary, that there was needed in this council structure an over-all coordinating body to which the others would report in essence, and that here in the National Advisory Council we would have a group that could attempt to pull all these different interests together.

The idea of getting specialists from all over the country on these councils interested in various fields is, of course, a very fine one, but unless they are coordinated their usefulness we feel would be somewhat limited.

Title VI of S. 1679, makes special provision for research in child life to be administered by the Children's Bureau. Over a period of years, the Children's Bureau has done an exceptional job in integrating the needs of children in the fields of health, welfare, and education. Up to the present time, it has not been authorized to make grants for research which could to best advantage be done in universities and other places. The Commission on Organization of the executive branch of the Government has recommended that funds be made available to the Children's Bureau for research grants and the APHA concurs in this recommendation.

The American Public Health Association recognizes that Administratively there are special features of the physical and mental health of women during maternity, of infants and children under 18 years of age. It is pointed out, however, that the provisions relating to grants to States for health services are contrary to the considered judgment of the American Public Health Association, that is, grants to be administered by the Children's Bureau, that a single responsible agency is a fundamental requisite to effective administration at all levels—Federal, State, and local.

It is admittedly important to have considerable provisions made for the services included in this title. These are now, for the most part, being administered through the channel of the Children's Bureau instead of the Public Health Service, and the association realizes that there may be reasons of expediency which justify temporary departure from the principles above stated.

May I express again my appreciation, and that of the American Public Health Association for the opportunity of appearing before this committee. It is quite apparent that I have omitted discussion of many phases of the bills under consideration. However, our association is vitally concerned with administrative problems, and we believe their importance should be stressed, which may not be done in any other testimony. If these problems are not wisely solved, it is unlikely that any of the plans being discussed will provide the high standard of services we all want.

Thank you very much, sir.

Senator MURRAY. Thank you, Doctor, for your very comprehensive statement, and study of the various bills. You find that all the bills have some feature that can be approved.

Dr. LEAVELL. We feel that is true, Senator.

Senator MURRAY. And after hearing your statement I am convinced that it would be very wise if Congress before enacting any bill in a hurry, should submit it to be very careful study by experts so as to discover any defects that might be in it. I think that you have given us a very fine statement here this morning. Thank you very much.

Senator Donnell has some questions.

Senator DONNELL. Doctor, I want to ask you a few questions. You referred at the outset of your statement to action taken by the governing council of the American Public Health Association in 1944.

Dr. LEAVELL. Yes, sir.

Senator DONNELL. By which action the governing council adopted an initial statement of policy relating to medical care in the national health programs.

Dr. LEAVELL. Yes, sir.

Senator DONNELL. Now that was the statement that was quite extensively testified to by Dr. Atwater.

Dr. LEAVELL. That was introduced in full.

Senator DONNELL. Yes, sir. I do not know whether you have before you or not—I assume you do not have it, but I have it here—the hearings on S. 545 in the Eightieth Congress, part 2, which contains the hearings of June 25, 26, and 27, and July 2 and 3, 1947. I will not take the time to give you this list of questions. I do not know whether you were here when Dr. Atwater testified or not.

Dr. LEAVELL. No, sir; I was not.

Senator DONNELL. Your name was mentioned in the testimony of Dr. Atwater. Do you recall whether or not the statement of 1944, which was adopted by the governing council of the American Public Health Association, arose out of action taken at the annual meeting of the committee on administrative practice of the American Public Health Association which annual meeting took place on October 9, 1943? Do you recall that?

Dr. **Leavell.** No. This was adopted, sir, in 1944.

Senator **Donnell.** I know it was. I did not make my question quite clear. I asked Dr. Atwater myself on page 873 of the hearings that were held in 1947, to which I have referred this question:

> In the first place, as I observe from the printed copy of the statement—

that statement, I think, was the same one you are talking about here—

> as I observed from the printed copy of the statement or the prelude to it as I understand it the statement arose out of action taken at the annual meeting of a committee of the American Public Health Association which annual meeting of that committee was held on October 9, 1943. That is correct, is it not?

Dr. Atwater said, "That is correct."

What I am getting at is not when it was adopted. It was adopted on October 4, 1944.

Dr. **Leavell.** Yes, sir.

Senator **Donnell.** As my notes indicate. Now, Doctor, if there is any of this you do not remember, do not hesitate to say so. I do not want you to testify about something you do not know, but in the testimony of Dr. Atwater it was pointed out by questioning and responses that the committee on administrative practice on October 9, 1943, directed the subcommittee on medical care to draft a set of principles expressing the desirability or desirable content of a comprehensive program of medical care and methods of its administration and the part which public health agencies should take in its operations.

I asked Dr. Atwater, "That is correct, is it not," and Dr. Atwater said, "That is correct."

Do you recall that to be a fact?

Dr. **Leavell.** Yes, I do. I was a member of that committee.

Senator **Donnell.** You mean you are a member of the committee?

Dr. **Leavell.** I was a member of the subcommittee on medical care.

Senator **Donnell.** That is what I meant. That consisted of 16 members. That is right, is it not?

Dr. **Leavell.** Yes, sir.

Senator **Donnell.** And Dr. Joseph W. Mountin was the chairman of that subcommittee, is that not correct?

Dr. **Leavell.** That is correct, at that time.

Senator **Donnell.** And Dr. Mountin was at that time with the United States Public Health Service?

Dr. **Leavell.** That is correct.

Senator **Donnell.** He was then and at the time Dr. Atwater testified still was Chief of the States Relations Division of the United States Public Health Service. That is correct, is it not?

Dr. **Leavell.** That is true; yes, sir.

Senator **Donnell.** And Dr. Mountin was, and I presume still is, located here in Washington. That is correct, is it not?

Dr. **Leavell.** Yes, sir.

Senator **Donnell.** I will not take you down over all the list of these 16 members, but there is a Dr. Edwin F. Daily who is one of the 16 members of that subcommittee on medical care. Is that correct?

Dr. **Leavell.** That is correct.

Senator **Donnell**. And Dr. Daily is connected or was connected with the United States Children's Bureau as Director of Public Health Service. That is correct, is it not?

Dr. **Leavell**. Well, that is not his exact title. He is in the Children's Bureau as Director of Medical Services.

Senator **Donnell**. At the time Dr. Atwater testified the doctor said, referring to Dr. Daily:

> He is at the present time Director of Public Health Service.

Dr. **Leavell**. I think it is a little different.

Senator **Donnell**. Proceeding with the testimony of Dr. Atwater, this statement was made to him:

> Now, Doctor, Dr. I. S. Falk, who is connected with the Social Security Board, next appears.

I ask you now, Doctor, if Dr. Falk was also a member of this subcommittee on medical care of which you were a member?

Dr. **Leavell**. He was.

Senator **Donnell**. And he, at the time of the actions of that subcommittee on medical care in 1944, at any rate, was Director of the Bureau of Research of the Social Security Board. That is correct, is it not?

Dr. **Leavell**. Yes, sir.

Senator **Donnell**. Now, Doctor, you are mentioned shortly after Dr. Falk here, Dr. Hugh R. Leavell, and Dr. Atwater states of you, and I ask you if this is correct, referring back, I think, to 1944:

> He was at that time commissioner of health in Louisville, Ky., and is now professor of public health administration at Harvard.

That is correct, is it not?

Dr. **Leavell**. Yes, sir.

Senator **Donnell**. Then John Perrott was also one of the members of the subcommittee on medical care, was he not?

Dr. **Leavell**. Yes, sir.

Senator **Donnell**. And he also was connected with the United States Public Health Service, was he not?

Dr. **Leavell**. Yes, sir.

Senator **Donnell**. And he was back in 1943 and 1944 during the deliberations of that subcommittee on medical care. Is that right?

Dr. **Leavell**. That is right.

Senator **Donnell**. And Mr. Perrott was also in 1944 at the time of those deliberations an alternate member or a substitute member of the International Labor Organization Permanent Inter-American Committee on Social Security. Do you know whether he was or not?

Dr. **Leavell**. I do not know about that.

Senator **Donnell**. I may say in fairness to you that Dr. Atwater said he had no knowledge on that question. That question was asked, but he did not know the answer.

Doctor, can we impose on you to come back at 2 o'clock?

Dr. **Leavell**. Surely, sir. I will be happy to do that, sir.

(Whereupon at 12:25 p. m., the hearing was recessed to reconvene at 2 p. m., this same day.)

AFTERNOON SESSION

Senator MURRAY. The hearing will be resumed.

Senator Donnell, you may proceed.

STATEMENT OF DR. HUGH R. LEAVELL—Resumed

Senator DONNELL. Dr. Leavell, I think shortly before the recess I had mentioned the name of Mr. George St. John Perrott.

Dr. LEAVELL. Yes, sir.

Senator DONNELL. As being a member of the subcommittee on medical care.

Dr. LEAVELL. Yes, sir.

Senator DONNELL. Without mentioning the others of the subcommittee, except Dr. Nathan Sinai, of the University of Michigan—he was a member also of that committee?

Dr. LEAVELL. Yes; he was.

Senator DONNELL. Do you recall that there was a meeting of that subcommittee held on about June 1, 1944, which was attended, I take it, by not only a quorum of the committee—I assume there was a quorum—but also by Dr. Louis S. Reed, do you remember that?

Dr. LEAVELL. I do not remember whether Dr. Reed was there. I remember the meeting, however.

Senator DONNELL. You do know Dr. Louis S. Reed?

Dr. LEAVELL. Yes.

Senator DONNELL. And he did cooperate at times with the committee on medical care?

Dr. LEAVELL. Yes; he did.

Senator DONNELL. And that is Dr. Louis S. Reed, of the United States Public Health Service; that is right, is it not?

Dr. LEAVELL. Yes, sir.

Senator DONNELL. Up to this point, Doctor, I have noted, just to get it back in mind, that the committee on administrative practices of the American Public Health Association had directed the subcommittee on medical care, composed in part of the persons whom I have meneioned, to draft a set of principles along the lines previously indicated in my questioning of you. Then I pointed out and asked you to some extent about the membership of that subcommittee on medical care.

Dr. LEAVELL. Would it be well to list the other members of that committee?

Senator DONNELL. I will be glad to do that. I am not sure that I have an entire complete list, but I have some of them here and I will be glad to put in those I have here. I will call those I have and you watch it, and you put in the others.

Dr. Earl G. Brown; Dr. David D. Carr; Mr. Graham Davis; Dr. J. Ray Hege; Miss Marion G. Randall; Dr. Edward S. Rogers.

That is all I have, I think, Doctor.

Dr. LEAVELL. I think Miss Faville.

Senator DONNELL. Who is Miss Faville?

Dr. LEAVELL. She was a nurse from Wayne University who was a member of the committee at that time.

Senator DONNELL. Not connected with the United States Government in any way?

Dr. LEAVELL. No, sir; with Wayne University.

Senator DONNELL. All right.

Dr. LEAVELL. And Dr. Emory Morris, president of the W. K. Kellogg Foundation.

Senator DONNELL. Mr. Dan Davis is also with the W. K. Kellogg Foundation?

Dr. LEAVELL. That is correct; he was head of the hospital division.

Senator DONNELL. So the persons whose names I have given, plus those you have added, constituted the entire membership of the subcommittee on medical care?

Dr. LEAVELL. Yes, sir.

Senator DONNELL. Now, the subcommittee on medical care itself, having been charged with this duty of drafting a set of principles, delegated to a smaller body the duty of drafting a set of principles, did it not?

Dr. LEAVELL. That was not exactly the case, Senator. This committee had been discussing that matter over a period of a number of months, and it was simply in the final stages that this smaller group drew together the principles which had been agreed upon in the general discussion.

Senator DONNELL. The smaller group submitted finally——

Dr. LEAVELL. They submitted a draft for consideration.

Senator DONNELL. That group was composed of Dr. Edwin F. Daily, of the United States Children's Bureau; Dr. Isidore S. Falk, of the Social Security Board; Dr. Louis S. Reed, of the United States Public Health Service; Dr. Edward S. Rogers, Assistant Commissioner of the New York Department of Health, and later dean of the University of California; and Dr. Nathan Sinai, of the University of Michigan. Is that correct, Dr. Leavell?

Dr. LEAVELL. Yes; I believe so.

Senator DONNELL. So that group of five were the individuals who actually prepared the draft reports which were presented to the subcommittee on medical care; that is correct, is it not?

Dr. LEAVELL. Yes, sir; and that was modified considerably by other members of the committee and in general discussion.

Senator DONNELL. Very well.

Did Messrs. Daily, Falk, Reed, Rogers, and Sinai sit in during the deliberations of the subcommittee on medical care while this draft was being considered?

Dr. LEAVELL. They were regular members of the committee. We felt they were useful men who had experience in the field and presented a different approach from those of us who were local and State health officers, and so on.

Senator DONNELL. I do not think Dr. Louis S. Reed was a member of the committee, was he?

Dr. LEAVELL. No; he served as sort of a staff assistant.

Senator DONNELL. He sat in with the subcommittee on medical care in consideration of these matters?

Dr. LEAVELL. Yes, sir.

Senator DONNELL. Now, after the draft report submitted as indicated by this group of five—Daily, Falk, Reed, Rogers, and Sinai—had been considered and altered and amended by the subcommittee on medical care, the result of their deliberations was ultimately, after passing through the committee on administrative practices and the executive board, turned over to the governing council of the American Public Health Association?

Dr. **Leavell.** That is correct.

Senator **Donnell.** That is correct, is it not?

Dr. **Leavell.** Yes, sir.

Senator **Donnell.** The American Public Health Association had somewhere in the neighborhood of 10,000 or 11,000 members, did it, at that time, 1944?

Dr. **Leavell.** I think at that time it was probably somewhat less.

Senator **Donnell.** Somewhat less?

Dr. **Leavell.** It has been increasing at about a thousand a year. I would judge something in the neighborhood of probably 8,000 at that time.

Senator **Donnell.** Eight thousand at that time?

Dr. **Leavell.** Yes, sir.

Senator **Donnell.** And the report, after having been submitted, as indicated, and considered and amended and so forth, finally on October 4, 1944, came before the governing council of the American Public Health Association at the annual meeting in New York City, is that correct?

Dr. **Leavell.** That is correct.

Senator **Donnell.** Now, Doctor, without going into the detail of it, which is quite extended and set forth in the testimony in 1947, there was quite a discussion with respect to this report, and comment as to the method of the selection of the governing council appeared in various articles in the American Medical Association Journal and in an article appearing in your own publication. What is the name of your publication?

Dr. **Leavell.** The American Journal of Public Health.

Senator **Donnell.** The American Journal of Public Health. Notably the editorial, I believe it is, or statement, at any rate, in the Journal of the American Medical Association—it was an editorial of October 14, 1944, and an article by Dr. W. G. Smillie which appeared in the publication of your organization.

Dr. **Leavell.** That is correct.

Senator **Donnell.** Now, Mr. Chairman, without further elaboration of this point, I request that without reprinting there be, however, incorporated by reference at this point in the proceedings of these hearings that portion of the hearings on S. 545 which appears in part 2 between pages 873 and 891, inclusive. As I say, I do not want to have it reprinted but I want to have the reference preserved here for convenience.

Senator **Murray.** The record will carry that reference.

Senator **Donnell.** Thank you, sir.

And Doctor, the official statement of policy to which you referred at page 1 of your statement of today as having been adopted in 1944 by the governing council of the American Public Health Association is the statement to which I have traced these various questions?

Dr. **Leavell.** That is correct.

Senator **Donnell.** That I have asked of you today?

Dr. **Leavell.** That is correct. I think it might be fair to say that the American Medical Association objected to the way our governing council was elected. I do not think our association has objected to that.

Senator DONNELL. Yes, the American Medical Association did.

Dr. LEAVELL. Yes, sir.

Senator DONNELL. That is right.

Dr. LEAVELL. And the method of election is not entirely dissimilar from the method of selection of the house of delegates of the American Medical Association actually, because a very considerable proportion of the membership of our governing council is elected from State component bodies—the Michigan Public Health Association, the Massachusetts Health Association, and so on—similarly to the State medical associations which elect members to the house of delegates of the American Medical Association.

Senator DONNELL. There are some differences, however, are there not?

Dr. LEAVELL. There are additional members of our association elected as members at large of the governing council. I think that is not true of the house of delegates of the American Medical Association.

Senator DONNELL. I see.

Doctor, in the main your statement rendered here today to us relates to administrative matters, does it not?

Dr. LEAVELL. Yes, sir, we purposely concentrated on those.

Senator DONNELL. You are not particularly expressing yourself on the subject of compulsory health insurance, the fundamental principles of it?

Dr. LEAVELL. We thought that would be handled adequately in other phases of the testimony, and since this was the particular phase of our competency and perhaps would not be handled elsewhere, we ought to concentrate particularly thereon.

Senator DONNELL. At page 12 of your statement you say:

> Eligibility for benefits under S. 1679 would be tied in intimately with the existing social security machinery and therefore a determination would be a very simple and exceedingly inexpensive process.

Dr. LEAVELL. Yes, sir.

Senator DONNELL. Now, in connection with that statement, Doctor, I should like to direct your attention to page 152 of S. 1679, particularly to subsection (f) of section 772, which appears on that page, 152.

Dr. LEAVELL. Yes, sir.

Senator DONNELL. I quote from that subdivision (f):

> Funds paid to a State for any class of personal health-service benefits shall be used exclusively for the provision of benefits of that class, except that the administrative costs of the State in administering personal health-service benefits under this title may be met from the allotments to the State. Such administrative costs, which in any fiscal year shall not exceed 5 percent of the aggregate allotments to the State for such fiscal year, shall be apportioned as between the several allotments in accordance with the costs of administering the respective classes of benefits.

Have you studied, Doctor, the question as to what the probable aggregate allotment to the States for the fiscal year would be in order to comply with the terms of this bill S. 1679?

Dr. LEAVELL. I have not; no, sir.

Senator DONNELL. So you would not be able to give us any figures on that?

Dr. LEAVELL. No, sir; I could not. You mean for administrative costs or over-all allotment?

Senator DONNELL. Over-all allotments.

Dr. LEAVELL. No, sir; we have not attempted to make an estimate of that.

Senator DONNELL. At this point, Mr. Chairman, I ask leave to incorporate in the record at this point these two sentences from an article under the heading for "Federal Diary" by Jerry Kluttz, appearing in the Washington Post of May 23, 1949, as follows:

> Between 35,000 and 45,000 new workers would be needed eventually to operate the proposed health program. Of that number about 5,000 would be at health headquarters here. The remainder would be Federal-State employees to run the program at the State level.

I will ask you, Doctor, to state whether you have made any estimate as to how many new workers would be needed eventually to operate the proposed health program under S. 1679.

Dr. LEAVELL. We have not attempted to do that in detail, no, sir.

Senator DONNELL. That is all, Doctor, thank you very much.

Senator MURRAY. Dr. Leavell, you were a member of the full committee on medical care of your organization, were you?

Dr. LEAVELL. Of the subcommittee on medical care. Actually I was representing the executive board as a member of that committee; yes, sir.

Senator MURRAY. And you attended all of the meetings?

Dr. LEAVELL. Practically all, I think.

Senator MURRAY. Was it participated in by all of the different members of the subcommittee, the discussions and studies?

Dr. LEAVELL. I think, sir, I have never been on a committee that worked more as a committee than this one did.

Senator MURRAY. Doctor, there was no one individual member of the committee that exercised influence or dominance over the balance of the subcommittee?

Dr. LEAVELL. I think that would be a very fair statement, sir.

Senator MURRAY. Then, after your committee acted on it, was there any other higher body that reviewed your findings?

Dr. LEAVELL. It passed up through the regular channels of the association, through the committee on administrative practices. It was published in the journal with requests for any comment that anyone might want to offer. And it was discussed at considerable length before the governing council.. It was the regular procedure; there was nothing abnormal about it.

Senator MURRAY. And you think that the recommendations that they made were sound and based on careful study of the situation?

Dr. LEAVELL. I do, sir. And there has been no indication that the association felt there has been a change since that time.

Senator DONNELL. Mr. Chairman, would you let me have one more question which I omitted to ask the doctor? I would like to ask him at this point, if I may.

Senator MURRAY. Yes.

Senator DONNELL. Dr. Leavell, have you given consideration to the relative importance of the public-health features of S. 1679 and those pertaining to prepaid personal health-insurance benefits, that is to say, the thing that you think is most important for the public welfare as between those two?

Dr. Leavell. I would have to express a personal opinion there. As I intimated, the American Public Health Association has asked the American Medical Association and the Public Welfare Association and the Hospital Association to join in sponsoring a small group to which various representatives of the consumer groups would be invited in the hopes we might sit down together as a group of voluntary associations and try to agree on a system of priorities.

I would simply be expressing my own personal opinion were I to do that now.

Senator Donnell. Would you prefer not to do that at this time?

Dr. Leavell. Well, it would seem to me—let's say this omnibus health bill is here, and if we want to look at it as a two-story omnibus, you have to step up to get onto the first story, and if you want to go on to the second story, you have to go some more steps to get there. And it would seem to me it would be possible, first, to develop a system of priorities, I would think, somewhat in the order they were mentioned when we discussed the problem of priorities on page 3 of the testimony which we submitted, with the idea that perhaps research ought to be brought a little higher than it is because it should certainly go coordinately along with training, construction, and the development of the local public-health units.

Senator Donnell. I take it that you assign very great importance to the public-health features of the bill.

Dr. Leavell. Oh, yes. And I think one of the values of this comprehensive approach is that it should make possible good coordination between the public health and medical care aspects.

Senator Donnell. I do not know whether there is a possibility of expressing an opinion as between the relative importance of the public health features and the other features of the bill. Are you prepared to express an opinion on that, or would you regard it as difficult if not impossible to do so?

Dr. Leavell. I think, if I could speak as a former health officer——

Senator Donnell. Yes, sir.

Dr. Leavell. Our responsibility is for the health of the public and not just what is considered the so-called public health. And I think if we were to ask a question, which I do the first day when my students are in class, I write up on the board. What do people want done about their health?

And these are public-health students. When we get that question answered we usually find that the main thing the people want done about their health is to have care provided for illness. And I believe that if we were to question a sample of our population we might find that would be borne out by the sampling technique.

Senator Donnell. Now, the American Public Health Association. What is the sense in which "public health" is used in that title?

Dr. Leavell. The health of the public.

Senator Donnell. The health of the public.

Dr. Leavell. As I indicated, we have a section on medical care. We feel that is an important segment of the total health of the public.

Senator Donnell. Yes, sir. You regard yourself as particularly qualified along the lines of discussion of these administrative problems and have, therefore, not gone into the fundamentals of compulsory medical-insurance features of the bill?

Dr. **Leavell.** I have had some experience with the various phases of the problem personally. I do know that all the aspects are important.

Senator **Donnell.** But you regard it advisable that the American Public Health Association through its spokesman here should express itself primarily along the lines of administrative features to which you addressed yourself?

Dr. **Leavell.** Yes.

Senator **Donnell.** That is all.

Senator **Murray.** Doctor, there was some discussion here today and yesterday with reference to the experience under the British medical-care system which is now in operation over there.

Dr. **Leavell.** Yes, sir.

Senator **Murray.** Are you familiar with the British system?

Dr. **Leavell.** I was in London for a year during the war. I had an opportunity to see what was going on at that time. And in the summer of 1947, on a travel grant from Rockefeller Foundation, I did study the plan which was being implemented at that time. The bill had already been passed.

This last February I went back at my personal expense to see what the situation was and try to be able to appraise it and get an impression of how it was developing.

Senator **Murray.** What is your impression of the operation of the act?

Dr. **Leavell.** Perhaps if I could read a first paragraph from an article that was recently published it might summarize that for you, if I might.

Senator **Murray.** You may do that.

Senator **Donnell.** May I ask, Doctor, who is the author?

Dr. **Leavell.** I am the author.

Senator **Donnell.** You are the author, all right.

Dr. **Leavell.** It was published in the May issue of the American Journal of Public Health, and the first paragraph reads:

> The British National Health Service is neither as bad as painted by those who fear compulsory health insurance in the United States nor as good as the British medical profession and the Ministry of Health would like to see it and hope it will become. We in the United States can learn much from this experiment now being conducted almost under our eyes if only we can look at it without emotional blindness. While the problem of the British is in many respects not comparable to our own, there are certainly sufficient similarities in background and outlook to make their experience valuable to us in developing our own plans for more adequate medical care. Failure to see defects in the present British situation, however, may be almost as dangerous for us as would acceptance at their face value of many current misrepresentations which are the despair of the officials of the British Medical Association.

I think perhaps that might summarize, Senator, the sort of general feeling about it that one gets.

You find almost no one who is prepared to go back to the old system. You find few people who are entirely satisfied with the present system.

I think you would have to say that the approach is that we have got some things that need to be corrected, and "let's set about correcting them."

Senator **Murray.** A great many articles have appeared in the newspapers and magazines of this country, and a great deal of discussion has been had in this country in recent months with reference to this system. And it seems to me, Doctor, there has been an effort to totally discredit it. And I notice that a great many jokes are told about it, about the people getting wigs, and getting more false teeth than they need, and all such stories as that. Did you find any justification for that kind of stories to be told?

Dr. LEAVELL. I was in London on some rather windy days, and I saw not a wig flying in either Piccadilly or Trafalgar Square.

Senator DONNELL. All wigs then were securely on the heads.

Dr. LEAVELL. I think it is unquestionably true that the British people had notoriously bad teeth, and the dental part of the service has been used to a much greater extent than was anticipated and is costing perhaps five times as much as was anticipated. That does not apply to the total picture.

Senator MURRAY. I remember reading in the newspapers some years ago that the situation of the people in England with reference to general care was very, very bad.

Dr. LEAVELL. Yes.

Senator MURRAY. I was told by a man who had visited the big industrial centers of Manchester and Liverpool, and those places—this was 25 or 30 years ago—that the women over there at 30 years of age had no teeth, they were losing their teeth, and there was no dental care for them at all.

Dr. LEAVELL. They are notoriously very bad.

Senator MURRAY. So, they must have been in a desperate situation over there when this law went into effect, and it would be only natural for the dental offices to be crowded.

Dr. LEAVELL. The dental aspects of the service and the eyeglass aspects are the ones which are costing considerably more than had been anticipated. The other parts of the service are not costing much more than had been budgeted, and actually the total cost per capita is running in the neighborhood of about $30, which was the cost estimated by the committee on the cost of medical care here in 1932 as being the cost of medical care here at that time. I do not think we can say that the cost therefore is astronomical in England at present.

Senator MURRAY. Did you meet or talk to any of the members of the medical profession when you were over there?

Dr. LEAVELL. A great many. I talked to the Secretary of the British Medical Association, the editor of the British Medical Journal, and a considerable number of general practitioners, and a good many of the public-health people, and the administrators of various parts of the program. I also talked to a good many British citizens that I met in the streets and carriages, busses and so on.

Senator MURRAY. Did you hear any expressions of hope that the program would work out satisfactorily after it was given a full opportunity?

Dr. LEAVELL. I would not use the word "hope." I think perhaps an expectation that this would work out properly would be a more accurate term than hope.

Senator MURRAY. It was an expectation that it would succeed?

Dr. LEAVELL. Yes. There is no talk of going back. It is a question of how can they improve the features that still are causing difficulties.

I think it is important to point out that the British Medical Association itself had recommended an extension of the preexisting insurance program there which provided only general-practitioner services to the lower-income groups, and the British Medical Association had on at least two occasions submitted so-called—I do not know whether they call them white papers, but they correspond to the Government white papers—papers recommending an extension of the service there.

Senator MURRAY. There was a desire, of course, to reserve for the medical profession as large a section of the population as possible that would not come under the program?

Dr. LEAVELL. I think nearly everyone has been surprised at how large a group have signed up under the program. Considerably more than 90 percent of the population, including the Royal Family, has signed up.

Senator MURRAY. And the public over there have come to accept the program and have expressed the feeling it was one of the best programs that has been established by the Government?

Dr. LEAVELL. I think that is true; yes, sir.

Senator MURRAY. You have noticed articles in this country, of course, criticizing and condemning it?

Dr. LEAVELL. I have.

Senator MURRY. You have noticed statements purporting to come from members of the British medical profession in which they condemn it and ridicule it. You do not think there is any justification for that kind of treatment of the act?

Dr. LEAVELL. Well, there is a relatively small group of members of the British Medical Association, headed by Lord Horter, who are attacking the system.

Senator MURRAY. And they never did come into the system?

Dr. LEAVELL. I am not sure whether they are in the system or not, but I do know a very high proportion of the total medical profession is in—better than 90 percent of the medical profession.

Senator MURRAY. That is all.

Dr. LEAVELL. Thank you.

(Subsequently Senator Murray submitted the following document for inclusion in the record:)

[Article appearing in the American Journal of Public Health, pp. 898–924, vol. 39, No. 7, July 1949]

THE QUALITY OF MEDICAL CARE IN A NATIONAL HEALTH PROGRAM [1]

(A statement by the Subcommittee on Medical Care)

INTRODUCTION

In October 1944 the American Public Health Association officially adopted a general policy statement on Medical Care in National Health Program (*1*). One of the three basic objectives recognized in the statement was * * *:

"Such a medical care program should ensure that the services provided be of the highest standard and that they be rendered under conditions satisfactory both to the public and to the professions."

Throughout the entire statement, emphasis was placed upon the quality of the health services to be made available.

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[1] This statement has been prepared by the Subcommittee on Medical Care of the Committee on Administrative Practice as a contribution to current discussions of medical care in a national-health program. The subcommittee believes that particular emphasis needs to be placed on factors affecting the quality of medical service in order to insure sound planning. While the statement is focused on medical care in a national health program, the principles set forth are considered to be applicable to all types of organized medical-care programs, including voluntary and public plans at the local, regional, State, or national level. Discussion and comments by interested readers are cordially invited.

It is the purpose of this supplementary statement to present the essential components of medical care of high quality and the methods by which these standards can be approached in a national health program.

The quality of medical care depends upon more than intangible, philosophical attitudes or particular personality traits on the part of those who render services. More is involved also than the technical content of the individual practitioner's work—basic as his may be. A high standard of care includes very definite scientific and organiaztional elements which can be incorporated into planning and which eventually will submit to measurement.

Since standards of health service reflect the ever-changing social and scientific patterns of the times, there can be no permanency to any particular set of qualitative standards for medical care (2). There is every reason to believe that scientific advances and progress in standards of living will take place in the future as in the past. A national health program must assure full freedom of experimentation and change in both the science and the organization of health service. It is recognized at the outset, therefore, that any concept of good medical care must be conspicuously dated.

Scope and Content of An Adequate Medical Care Program

OBJECTIVES

The objectives of medical care in a national health program must include:

1. Promotion of positive health.[2]
2. Prevention of disease, disability, and attendant economic insecurity.
3. Cure or mitigation of disease.
4. Rehabilitation of the patient.

It is recognized that medical care is only part of a total health program. Thus, most measures for the promotion of health are broadly social or educational in character, relating to employment, housing, nutrition, economic and social security on the one hand, and to recreation, physical and health education on the other. Also, prevention of much illness, at least for water- and milk-borne and occupational diseases, can be accomplished without recourse to individual service by medical personnel. It is essential, however, that the medical care aspects of a national health program be planned with the total picture in mind. Such planning makes it possible to orient medical service not only toward treatment of disease but also toward promotion of health, prevention of illness and rehabilitation of the patient in a social as well as a medical sense.

QUANTITATIVE ADEQUACY

Adequate medical care must meet both quantitative and qualitative standards. Quantitative adequacy involves both comprehensiveness and balance. This implies the provision of all services required to achieve the above-named objectives, in proper amounts and with effective timing. Essentials for such quantitative adequacy include:

1. Participation of medical, dental, nursing, social service, technical, administrative, educational, and supporting personnel sufficient to provide the full range of modern scientific care.
2. Provision of care in home, office, clinic, health center, general hospital or specialized institution, according to the best interest of the patient.
3. Provision of drugs, appliances, laboratory services, and other aids.
4. Application of all relevant services to illness, injury, defect, and maternity—and to preventive care for the apparently healthy.
5. Education of the public as to the wisest and most efficient utilization of all available health services.

It is recognized that services are frequently inadequate at the present time and cannot be uniformly provided for everybody, everywhere, when a national program is instituted. The policy must be accepted, however, of providing the maximum that is feasible through the use of existing resources and of extending services as rapidly as medical and financial resources become available.

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[2] The Constitution of the World Health Organization defines positive health as " * * * a state of complete physical, mental, and social well-being, not merely the absence of disease or infirmity."

QUALITATIVE ADEQUACY

The components of qualitative adequacy may be considered as fivefold:

1. Able, well-trained, and efficiently functioning personnel.
2. Facilities and equipment which meet high technical standards.
3. Health services which encompass the best knowledge of modern medical science, and which insure availability and continuity of care.
4. Adequate financial arrangements, making possible the timely provision of all indicated services, without economic deterrents for patients or practitioners.
5. Sound administrative organization and operation, designed to promote efficiency and economy of service.

Each of these factors is, of course, inseparably related to the rest. Effective health service requires competent personnel and facilities of high standard. Sound financing is a sine qua non of any successful program. Subsequent discussion will consider the organizational methods by which these five basic components may be related to each other, and to the achievement of the goal of high quality.

Components of Good Quality

PROFESSIONAL AND RELATED PERSONNEL

The quality of medical care is dependent on the competence of those rendering a highly personal service. Obviously, therefore, the standard of care in an organized program will reffect the individual abilities of the participating professional personnel. Such professional competence, in turn, depends upon careful selection of trainees, adequate educational programs, and desirable patterns of practice. If, thereby, competent personnel with sufficiently diversified skills are available in adequate numbers and in equitable patterns of distribution, the first criterion of quality will be satisfied.

Physicians

Selection and education.—Preprofessional college education can be redesigned to prepare more broadly oriented students whose knowledge of the humanities and the social sciences will improve their later application of the natural and medical sciences.

Selection of medical students should be based increasingly upon objective appraisal of broad qualifications as suggested by the newer techniques of scientific testing (*3*) and upon evaluation of applicants without bias on grounds of sex, race, religion, or nationality (*4*). The impersonal—but nonetheless formidable—barrier of prohibitive student costs threatens to restrict the profession to members of upper-income groups, unless increased financial aid is made available to students and to medical schools (*5*).

Undergraduate medical education must be continually appraised in terms of the changing requirements of the times. The most pressing current need is for proper emphasis upon the interrelationships among the various academic department (*6*), and for production of physicians who are aware of the social as well as the scientific responsibilities of their profession (*7*). Pediatrics, psychiatry, geriatrics, and preventive medicine all need strengthening in the curriculum. No medical student should be graduated without study of the psychological, social, economic, occupational and other aspects of "total" patient care. No graduate should lack an introduction to the principles of medical-care planning and organization. Such instruction is best facilitated when the school participates actively in organized community programs of health and medical care. A major role of the medical teaching center of the future will be found in its relationship to the regional health service network described below (*8*).

Graduate education in medicine is currently characterized by an extreme unevenness of quality. Less than one-third of hospitals approved by the American Medical Association for intern and resident training are affiliated with medical schools. Wider affiliation of teaching centers with training programs of small hospitals could produce major contributions to the quality of medical service throughout the Nation. Greater emphasis seems also needed upon the extra hospital phases of medical education. The graduate should have experience in out-patient service, home care, social service, public-health practice, rehabilitation, and rural, and small community hospitals. This, too, may perhaps best be achieved within the framework of a coordinated hospital plan.[3]

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[3] Medical schools currently engaged in planning for such graduate education include Colorado, Medical College of Virginia, Michigan, New York University, Rochester, Tulane, and others. Descriptive literature can be obtained from the schools.

Postgraduate education for practitioners of medicine is an important phase of quality of care. Programs for postgraduate education can be developed most effectively through (1) special financial provision for postgraduate studies, and (2) coordination of teaching centers and outlying community hospitals in functional regional networks. Within such regional programs, consultants and instructors from the teaching centers can travel out for local meetings, clinics, and ward rounds; practitioners in outlying areas can move to the regional centers for formal courses, training conferences, and demonstrations[4] (*9*).

The financial problems in medical education mark the limiting factor in the practical attainment of higher goals in both undergraduate and graduate education. Most university authorities and medical educators are now stressing the critical need for more adequate financial support of medical and related professional schools (*10*).

Allocation of funds for education and training within the financial framework of the medical-care program can do much to elevate standards of professional care. Special emphasis can be placed on the support of postgraduate education so that economic deterrents do not operate and teaching institutions are enabled to develop the needed resources. Funds might be particularly applied to training those classes of health workers now in short supply.

Such steps in themselves, however, could not solve the entire financial crisis in which medical education now finds itself. Carefully designed support to institutions and to students is needed on a national grant-in-aid basis.

Medical licensure.—The lack of uniformity in State licensure provisions and of sufficient reciprocity among the States has been a deterrent to the achievement of national standards or an improved distribution of physicians. In some States, rigid or unusual prerequisites for licensure prevent desirable flexibility and adaptability in medical education. Achievement by the States of greater interstate reciprocity and similar high standards of licensure, or common acceptance of the diploma of the National Board of Medical Examiners, would greatly ease this situation.

It has also been suggested that the qualifications of licensed practitioners be reviewed periodically in order to safeguard the quality of care provided. This proposal deserves further study and consideration.

Patterns of medical practice.—The patterns of practice among physicians affect both the volume and the quality of the medical service rendered. It is a basic principle of planning for medical care of high quality that physicians and other personnel should be closely associated, operating together as a balanced medical team. The greatest single deterrent to good service is the isolation of the individual practitioner from his colleagues. The patterns of practice should therefore be such as to enable practitioners to utilize readily the skills of consultants and other specialized personnel, and to benefit from the stimulation of continuing professional contacts. They should have easy access to library and other educational resources, be free from the burden of nonprofesional chores, and have sufficient time and incentive to read, attend lectures, visit medical centers, and otherwise improve their knowledge and abilities.

Medical service of good quality is best promoted by the closest possible functional relationships between general and special physicians. The general practitioner can serve as the key person in the treatment of the individual patient, concerned with the total aspects of the case—medical and social—and freely referring the patient for specialty and consultant care when needed. Barriers to indicated referrals and financial irregularities in connection with such activity can be removed by sound administrative policy. This requires elimination of those financial factors which promote fee splitting and rebate practices on the one hand, and those, on the other, which deter the family practitioner from calling in a consultant because of additional cost to the patient or fear of "losing" the patient. Modification of the traditional fee-for-service method of compensating physicians is strongly indicated. Methods of remuneration should be such as to be equitable both to the general practitioner and the specialist, and to encourage proper referral. There should also be careful experimentation with full-time salaried consultants and with routine consultation procedures in selected circumstances.[5]

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[4] Significant postgraduate programs have been developed in the regional plans of the Bingham Associates Fund based in the New England Medical Center (Boston) and of the Council of Rochester (N. Y.) regional hospitals.

[5] Such as Caesarean section, amputation, etc.

In clinics and hospitals, the goal of closer relationships between general and consulting physicians is approached by the creation of efficient referral procedures, definite appointment systems, interdepartmental conferences, and the like. With the receipt of complete consultation reports, the general practitioner can usually continue with the management of all but the most specialized therapeutic procedures.[6]

It is obviously impossible for rural areas and very small communities to support the full-time services of all necessary medical specialists. Improved general practitioner-specialist relationships are attainable through the regional organization of medical services. Under such a plan, physicians of smaller communities become functionally associated with specialists in larger centers. As a result, referral of patients is facilitated and there are more local requests for visiting consultants. In effect, the rural practitioner becomes a member of a regional "medical group."

Increased rates of payment for specialty service in an organized medical-care program should, in the interest of quality, be limited to physicians who meet objectively established standards of special qualification. Overemphasis on American Specialty Board certification can be avoided if ample provision is made for acceptance of equivalents in training and experience, to be evaluated by competent professional councils. One approach to this problem is that of the Health Insurance Plan of Greater New York, in which specialists are designated on any of three bases: Board diplomas, teaching-staff appointments, or individual qualifications.

The current practice of direct choice of specialists by the often confused patient represents an undesirable form of self-diagnosis and frequently involves much waste of time and money. Channeling of specialty referrals through a general physician or a specialist to whom the patient has been previously referred (including provisions for such referral in special cases by the medical administrator in the local area) would avoid many of the inefficiencies of unsupervised medical "shopping." Special procedures would, of course, be necessary for emergencies and for the somewhat different circumstances of pediatric, obstetric, and similar specialties where the patient can properly make a direct selection of the specialty.

Diagnostic aids: Modern scientific medicine requires that the able and well-trained physician have access not only to consultants but also to the technical diagnostic and other laboratory procedures so essential to clinical accuracy. Despite the development of well-equipped and well-staffed laboratories in the better medical centers, many practitioners are not connected with hospitals; many have no ready access to private laboratories or are located in isolated rural and semi-rural areas. The office laboratory is no longer capable of supplying all the required aids to the modern physician.

A significant development would be the establishment of integrated diagnostic facilities throughout a State or regional area, available to all practitioners in the vicinity. Such diagnostic facilities might be best developed as part of public-health centers or community hospitals and clinics, and would serve their purpose most efficiently if correlated with the over-all functions of public-health agencies and regional hospital networks. This could effectively promote development of proper diagnostic assistance for those rural practitioners whose small communities cannot support extensive laboratory facilities. Specimens, pathological tissues, X-ray plates, and the like could then be sent to the cooperating district or regional centers, while periodic visits could be made to local communities by pathologists, radiologists, and associated technicians from the larger centers.

It is essential that a national health program include the services provided by diagnostic laboratories, and such facilities should be adequately reimbursed by the plan—unless established under separate public auspices (*11*).

Group practice: The efficiency and quality of medical service rendered by a coordinated group of qualified general physicians, specialists, and auxiliary personnel is being increasingly recognized. Group medical practice facilitates coordination of the personnel and facilities essential to medicine of high standard. It provides ready access to consultants and the technical services of trained auxiliary personnel, and permits full use of complex laboratory, X-ray, electrocardiographic, and other diagnostic facilities (*12*). The constant intragroup contacts in professional work are a primary stimulus to continuous education. Professional supervision of professional services can, moreover, be developed effectively in an organized group, while such quality controls are difficult to maintain in individual practice (*13*).

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[6] Efforts to enhance the prestige of the general practitioner have included establishment of general-practice sections in hospitals and medical societies. A "specialty board" in general practice is also under discussion.

Group practice is advantageous to the administration of a medical-care program in a number of ways. More service can be rendered per unit of expenditure by groups than by individual practitioners, as a result of economies in organization of personnel and equipment. Overhead costs of operation are reduced. Administrative detail is simplified by the integrated structure of the service unit.

The effectiveness of the group-practice method is further enhanced through the common use of a central well-equipped facility—hospital or health center—as the base of operations for the group. Here all needed personnel and equipment can be concentrated for the most efficient service to the public. Wasted time and effort on the part of patients referred from one clinic or specialist to another can be avoided. Close relationships with public health and hospital services can be fostered. Wherever feasible, medical groups should be affiliated for teaching and research purposes with nearby medical schools.[7]

The very real limitations and possible abuses of group practice are not to be minimized (*14*). Unless a broadly trained practitioner has over-all responsibility for the patient, there is danger of overspecialization and excessive referrals within the group. Hurried and impersonal work should be avoided in group practice as well as in individual practice. Financial arrangements satisfactory to all group members are sometimes difficult to work out, as are methods of supervision and control. With sound organization, however, group practice can function to the decided advantage of both physician and patient.

A forward-looking national health program should give every encouragement to the growth of group medical practice. Clear provision should be made for the participation of qualified groups in the provision of services. Such groups should receive payment at the same rates as nongroup practitioners, whether on a fee-for-service or capitation basis, the total amounts being determined by the range of services provided and the number of persons served. Any economies achieved by the group-practice method should not be justification for a rate of payment to medical groups lower than that to nongroup practitioners. Rather, such economies should result in improvements in the quality of service provided by the groups and in increased incomes for the physicians and other personnel associated with them. Medical groups should be free to decide their own internal methods of professional remuneration. Because of the intimate association of its members, a medical group is in an especially advantageous position to appraise competence among its physicians (and others) and to reward such competence in a fair and discriminating manner. With this desirable flexibility of remuneration, a group's internal arrangements can be made especially conducive to improvements in quality of care.

A national health program might well offer assistance in the form of grants to public and nonprofit agencies and long-term loans for capital construction and equipment to such professional groups as give promise of increased efficiency, economy, and quality in the provision of services under the program.

Dentists

All of the principles enunciated above with respect to medical personnel are pertinent to the dental aspect of health service of high quality. Dental care should be included in the services provided in a national health program to the extent that available resources of dental personnel make possible. The current severe shortage of dentists and auxiliary dental personnel, however, necessitates a temporarily limited horizon for the provision of dental care to the public (*11*). Current emphasis must be directed to preventive and protective dental care for children and to essential therapy for adults. Concurrently, a threefold attack on the overwhelming problem of dental disease in the Nation can be made by: (1) Training larger numbers of dentists and other dental personnel; (2) use of multiple chairs by dental practitioners and the performance of subsidiary dental functions by auxiliary personnel under professional supervision in order to increase the number of patients who can be served by a dentist and to achieve reduction in the unit costof dental service (*15*); and (3) increased research into the causes and methods of preventing and controlling the major dental disorders. Utilization of new types of auxiliary personnel capable of carrying out certain dental functions has been proposed many times in the past and is now receiving more favorable attention (*16*).

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[7] For example, the New York University and Montefiore Hospital (Columbia University) units are affiliated with the group practice service of the Health Insurance Plan of Greater New York. The Hitchcock Clinic is similarly closely associated with the Dartmouth Medical School.

Regionalism in health planning has the same application to dental as to medical practice, and the dental specialist should be an integral part of every comprehensive medical group, clinic, and hospital service (*17*). Financial aid for education from public sources should include the professional dentist, the dental hygienist, and other auxiliary personnel—trained together for coordinated team functions.

Nurses

Services of professional and practical nurses form the third essential of the modern medical team. Nursing education programs should be planned in conjunction with known and predicted community needs for all phases of nursing service. The present great gap between needed nursing services and available nursing personnel emphasizes the importance of this consideration.

Education for professional nursing should be broadened to include more adequate academic preparation; experience in community, home and small hospital nursing; and emphasis upon the social and psychological aspects of patient care. Opportunity should be provided for the advanced training of needed supervisors, teachers, public-health nurses and specialists.

An excessive number of existing schools of nursing are low in student enrollment and affiliated with relatively small and isolated hospitals. Here the caliber of teaching is frequently poor and the demand for nursing service from the students is undesirably high. The quality of nursing care in general can be enhanced by greater concentration of professional nursing education in University-affiliated teaching hospitals with large enrollments (*17*).

Opportunity should also be provided for adequate education of practical nurses. It is becoming increasingly recognized that planning for nursing education should take into account the need for nursing service at different levels in order to meet present and future demands for health services and care of the sick (*18*).

While the present shortage of nursing personnel emphasizes the need for nurses' aides and orderlies to carry out routine mechanical duties, such allocation of duties is even more important from the viewpoint of increasing the efficiency and improving the quality of nursing service. Provision should also be made for the special nursing of single or grouped hospital patients whose clinical condition warrants such care. This would make it possible to curtail the wasteful use of private duty nurses; it would release many of these nurses for other types of service and would improve the quality of care by providing concentrated nursing care where it is medically indicated. In appropriate home care cases, nurses can be helped to provide more effective service through the use of trained and supervised housekeepers and "mothers' helpers."

State licensure for both professional and practical nurses is essential. The extent to which such licensure can be standardized, in ways similar to those recommended for physicians, will determine to a considerable degree the effectiveness of attempts to achieve a more rational distribution of nursing personnel among the States.

Standards for participation of both professional and practical nurses and of housekeeping aides should be established in a national health program. Home nursing and special duty nursing in the hospital should be paid for, but only when medically indicated. The inclusion of nurses and schools of nursing in the program of grants-in-aid for education and training is imperative if necessary improvements are to be achieved. Refresher and postgraduate education is as significant for nurses as for physicians and dentists.

Medical social workers

The influence of social factors in the production of disease and in restoration of health is of great significance. No medical service plan can achieve high standards without the well-integrated services of fully qualified medical and psychiatric social workers (*19*). These workers play an essential role in determining the social factors which may affect the response of a given patient to illness and to medical care, and in assisting the patient to use the medical services of the community to achieve the optimum rehabilitation possible in terms of his physical and social capacities. Social service should be utilized by clinics and practitioners as well as by hospitals and health agencies. The activities of the public health nurse and the medical social worker should be closely coordinated. The organized group practice of medicine affords the most practical opportunity for social work to permeate the day-to-day management of ambulatory and domiciliary medical cases.

Medical administrators

Good medical service depends constantly on the efficient, orderly, economical, and resourceful management of the administrative phases of the program. Qualified professional personnel, however, are not necessarily experts in the field of medical, hospital, and public health administration.

The proper training of administrative personnel—both lay and professional—is as essential as sound preparation for any of the clinical specialties. Graduate courses in medical administration should be further developed, based upon a solid grounding in the health sciences and integrate with practical field training. The university schools of public health seem to be the proper places for the needed expansion of such training efforts.[8] A national health program should contain carefully formulated standards for administrative personnel, and should include such personnel in the program of grants-in-aid for education and training.

Pharmacists and drug therapy

Modern advances in chemistry, pharmacology, and serology have produced an extensive armamentarium of therapeutic agents essential to medical care of high quality. To insure the successful use of these therapeutic agents in a national medical-care plan, competent and scientifically trained pharmacists should be component parts of the medical-service team, and should be active participants in the organized medical-care program. With their cooperation, the evil of uncontrolled use of patent medicines and home remedies can be greatly reduced and drug therapy more nearly limited to the utilization of ethical products listed in a professionally compiled formulary or included in one of the official pharmacopoeias. Good quality of care also requires rational and judicious use of all medicines. Multiple "shotgun" prescriptions should be avoided. The routine use in prescription writing of basic pharmaceutical compounds and nonproprietary names should be strongly encouraged (*20*).

Administrative procedures which control the multiple abuses of drug therapy are essential to any medical plan of good quality. Payments from public funds should be limited to drugs provided upon prescription and should be confined to professionally approved items. Administrative and financial considerations require limitation of payment for drugs to preventive, long-term, and especially valuable and expensive medicinals (*11*).

Other health personnel

Utilization of other professional health workers under competent medical supervision is essential to service of high quality. The full range of medical care today includes the services of the physical therapist, the clinical psychologist and the occupational therapist, as well as the optometrist and the podiatrist. Each of these groups has a significant contribution to make in the treatment and rehabilitation of the patient. The importance of interprofessional teamwork and closer coordination of the activities of all types of health personnel cannot be overemphasized.

Sectarian practitioners

Many factors have combined to encourage the appearance of large numbers of sectarian practitioners, quacks, and charlatans and their use in the provision of care to the American public. To the extent that these partially trained and untrained individuals render service to patients, the quality of the system of care degenerates. Factors which underlie the existence of such practitioners include: (1) Shortages of medical practitioners, (2) maldistribution of professional personnel, (3) high cost of modern medical care, (4) inability of medical science to cope adequately with many problems of chronic disease, (5) failure of many practitioners to consider properly the emotional and social factors in medicine, (6) discriminatory practices which prevent minority population groups from receiving adequate medical services, (7) looseness of many State laws governing medical licensure, and (8) inadequacy of health education.

High standards of service in a national program require efforts to control the activities of sectarian practitioners by—

1. Elimination of all untrained practitioners such as chiropractors, faith-healers, naturopaths and others, from participation in the payments for health services to individuals under the program.

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[8] Organized courses in medical-care administration are currently offered at the schools of public health at California, Harvard, Johns Hopkins, Michigan, and North Carolina. Special training for hospital administrators is available at California, Chicago, Columbia, Minnesota, Northwestern, Toronto, Yale, and other university centers.

2. Elevation of the educational standards of those groups now close to the concept of scientific medicine, as are certain groups of osteopaths, through financial and technical assistance to approved schools. This could make possible eventual incorporation of such personnel and their teaching institutions and hospitals into the regular ranks of medical personnel serving the public.

Research

A fundamental component of medical care of high quality is the constant and unfettered development of research studies in natural science, clinical medicine, social and economic aspects of disease, preventive methods, and administration (*21*). The many unsolved problems in prevention and control of disease and in methods of medical care organization require the fullest possible research activity on the part of persons involved in the service program as well as those devoting full time to investigative work. A national plan for medical care should promote a better quality of services by providing opportunity within the program for professional and administrative personnel to utilize its operations and facilities for research purposes.

HOSPITALS AND RELATED FACILITIES

Able, well trained and efficiently organized professional personnel can render services of high quality only when they and their patients have easy access to modern medical facilities which meet scientific standards and are efficiently coordinated for service. These should be developed through careful community and regional planning and must be supported by greater public and private financing, with the goal of providing an adequate number of balanced and equitably distributed facilities.

Hospital standards

Although existing professional associations have made real progress in elevating standards of hospital care, serious gaps still persist. Only two-fifths of all hospitals have the approval of the American College of Surgeons, and only a sixth are approved by the American Medical Association for intern and resident training (*22*). Proper standards and qualifications have been worked out in detail for very few of the special types of hospitals (*23*). Uncontrolled and frequently inadequate proprietary institutions still exist in many communities—and indeed are increasing in some places for many of the same reasons that underlie the prevalence of quack practitioners and the use of patent medicines.

It is essential to the operation of a sound medical-care program that careful standards for the approval of all types of health facilities be developed. The official health agencies of most States are now empowered to inspect and license general hospital facilities. The State agencies should supplement enforcement of licensure standards with positive efforts to aid the poorer hospitals in improving their facilities and meeting the conditions for approval. Competent hospital consultant personnel are needed for this function. The private professional organizations should expand their activities in developing and promulgating general standards as well as special certifications necessary to the advanced educational and professional activities of the better hospitals. The role of the American Hospital Association in the formulation of the "model law" for State hospital licensure is an example of the responsible discharge of such professional obligations.

Where no licensure standards exist or where existing standards are not applicable or adequate, the administrative agency in a medical care program should formulate basic requirements for participation of hospitals.

Regional coordination

There has been extensive development of plans for the regional affiliation of rural, semiurban, and metropolitan hospital facilities. The Public Health Service, the Commission on Hospital Care, various foundations and universities, and others have laid the conceptual groundwork for this regional approach to the many vexing problems of medical care, medical education, and hospital service (*24*). This approach calls for the functional coordination of all health facilities in a region to form a network based on natural geographic lines and medical service areas. Outlying rural health centers and community clinics are related to small community hospitals in the more populous localities. These in turn affiliate with larger district hospitals, and all converge on the teaching institutions of metropolitan centers. Public-health departments, nursing homes, special hospitals, and other facilities are integrated in the system at appropriate levels.

The network involves, as indicated previously, a two-way functional flow of medical services, professional trainees, consultants, diagnostic laboratory aids, and the like. In this way, the limited resources of rural and suburban facilities can be efficiently supplemented by the readily accessible services of district and base centers. Continual referrals, training, supervision, and technical assistance all serve to maintain a high level of professional quality throughout the region *(8)* *(17)*.

This principle of efficient regional coordination of medical and hospital services should be fundamental in the design of a national health program. Administration of the program should be decentralized to functionally sound regional areas and local health districts which take into account the natural flow of trade and medical service. Effective coordination of hospital regions and local public health districts could thus be implemented.

Once a national program managed to achieve the removal of financial deterrents to medical mobility within a region, any interested area would be better able to arrange the necessary service affiliations between metropolitan and local hospitals, between medical center specialists and small community practitioners, and the like. Funds allocated to peripheral communities would be available to pay for those laboratory, consultant, and other services obtainable only from the large centers of the region. Under a national plan, most or all residents of a region would be eligible for services at any level of the network, thus eliminating one of the most important impediments in current regional plans—the lack of adequate financial arrangements for purchasing the services available at all levels.

A national health program can assist teaching centers to assume their key role in the regional medical care system through educational grants-in-aid as discussed previously. Training stipends for professional and technical personnel would enable those in outlying areas to take full advantage of the educational opportunities in the more highly developed hospital and related resources of the region. Grants-in-aid to health departments, universities, and other public and nonprofit organizations should be made available for assistance in the planning and development of coordinated hospital and health center systems.

Hospital staff

General elevation of medical standards requires the closest possible contact of all practitioners in the community with the hospital facilities that are available. Good care is impossible to provide in isolation from the consultants, laboratories, equipment, and other facilities of the modern hospital. It would seem desirable, therefore, to reverse the accustomed closed staff arrangements and allow all licensed practitioners to utilize the hospital, but they should be restricted to activities within their scope of competence and constantly supervised and aided in their work by the whole professional staff of the institution. This would contrast favorably with the present custom of forcing the least able, the least popular, or the late-arriving physicians into total isolation from the benefits of modern hospital centers. As more experience is gained with open staff organization, standards for hospital participation in the national program might reflect this principle.

Full-time staff.—A growing tendency is discernible toward the establishment of full-time hospital staff nuclei, whose salaried members constitute an effective group practice unit for patient service, consultations, teaching, and research in the hospital. Many of the top-ranking university hospitals of the Nation have long maintained full-time medical staff personnel. This development serves to enhance the quality of hospital and out-patient care and provides the affiliated part-time physicians with a source of valuable assistance. As Peters has pointed out *(25)*, more adequate public support of the beds utilized for care of the medically needy would enable hospitals to offer satisfactory salaries to qualified full-time physicians and thus greatly extend the scope of this movement. Affiliation of community hospitals with medical schools in regional programs would also stimulate this practice.

Even more effective would be the full-cost payment to hospitals for the care of the needy that would be made under a national medical care program. With cost reimbursements for all or nearly all patients, hospitals would be in a far better position to retain full-time staff, to support research and teaching, and to provide consultants and special services for affiliated outlying hospitals.

Specific provision should be made in the plan of payment to participating hospitals for the inclusion of salary funds for full-time staff members. This, together with the guaranty of hospital reimbursement for all or nearly all patients, would provide the financial basis for vastly improved hospital care.

Staff organizations

Continuous maintenance and elevation of standards within the hospital depend upon conscientious organization of the clinical staff and upon its educational and self-appraisal activities (*26*). Recognized functions of good hospital staffs include regularly scheduled conferences, analysis of previous hospital experience, and review of problem cases and of unexplained deaths (*27*). Chiefs of service can judge the general quality of their departments through such objective criteria as the number and type of consultations, frequency rates for certain categories of surgical and other therapeutic procedures, autopsy ratios, record keeping, incidence of preventable complications, utilization of laboratory services, and the nature and number of referrals to social service.

A useful device for the encouragement of high levels of staff performance is the so-called medical or statistical audit which has been used for many years by a few leading hospitals and is now coming into more general favor (*28*). This is a periodic audit by the entire medical staff of the work performed in the hospital. The necessary requisite is comprehensive and uniform record-keeping on the part of the medical staff. On the basis of these records, statistical tabulations and analyses are compiled which show the morbidity and mortality experience of each service and each individual staff member during the period involved. Initial diagnosis and prognoses are compared with the results of hospital treatment. Such analyses, carefully made and interpreted, become the basis for self-education and improvement, for staff appointments and promotions, for evaluation of new procedures, and for the discovery of sources of poor work in the institution.

The quality of hospital care correlates directly also with the caliber and activity of the personnel conducting pathological and radiological services in the unit. Persons responsible for these technical specialties must be fearless and honest in their diagnostic work if first-rate medicine is to be practiced and if unnecessary and unwarranted therapeutic procedures are to be minimized.

All such elements of quality in hospital service should be reflected in the standards and procedures set up under a national program for medical care.

General and special hospital relationships

Technological advances in medical science and the unplanned development of community health facilities have resulted in an uncoordinated maze of chronic, mental, tuberculosis, communicable diseases, maternity, and other special hospital facilities. Highest standards of medical care, however, call for the physical unification of special hospital facilities within the framework of the general hospital plants. If planned construction of this nature is not immediately feasible, the closest possible administrative and functional relationships should exist between the parent general hospital and subsidiary special institutions (*29*). Within regional areas of service in a national program, special long-term facilities can be affiliated with general hospitals at appropriate levels.

Such coordination of general and special hospital facilities is essential if continuity of patient care is to be achieved in a medical care program. Proper medical supervision of nursing, convalescent, chronic, and other institutions by the active staffs of affiliated general hospitals is possible only in this way. The most economical use of all the physical and human resources of the various units of the hospital system is thus realized. Finally, financial and other deterrents to the easy transfer of patients from one institution to another can be overcome only when all facilities in an area are functionally coordinated and jointly participate in a single financial plan.

Transportation services

A necessary component of a coordinated and comprehensive system of home, office, and hospital care is the provision of good ambulance service. The smooth functioning of the regional hospital plan also depends to a considerable degree upon the efficiency of the system for transporting patients, personnel, and diagnostic specimens.

The modern concept of ambulance service might well include provision of air transportation for patients living in remote areas, for those isolated by impassable road conditions, and for those requiring immediate care in a specialized facility. Such service should be arranged in relation to the regional hospital plan so that patients can be treated in the nearest facility competent to provide the care required. The advantages of air transportation for rural and mountainous areas have never been fully investigated, apart from the extensive war experiences and the experiments in Australia, Saskatchewan, and a few other countries. The combination of outpost health centers containing the medical essentials, plus quickly available air transportation to fully equipped hospitals and medical centers, may serve to alter some current concepts regarding the best means for providing medical care to outlying areas.

It would seem essential to the goal of high quality that such services be included as rapidly as feasible in a national plan, following full experimentation in selected areas.

Relationships of hospitals and health departments

A recent statement of the American Hospital Association and the American Public Health Association has emphasized the advantages of joint housing and cooperative functioning of hospitals and health departments (*30*). By such joint activity, the services of each can be strengthened, continuity of care can be facilitated, and the necessary rapprochement between preventive and curative medicine can be encouraged. With the increasing assumption of administrative responsibility by health departments for State and local operation of medical services—as urged in the 1944 A. P. H. A. statement (*1*)—official health authorities are becoming more closely associated with hospital problems. A real impetus toward coordinated activities and joint housing can be foreseen in this connection.

The logical development of all aspects of hospital and related care leads to a broad concept of the community health and medical center, from which can emanate the fully coordinated and balanced health services needed by a local population. This involves not only the joint housing of hospitals and health departments, but acceleration of the discernible movement toward establishment of offices for private physicians and medical groups within the hospital proper. Thus, the role of the community hospital is strengthened as the total medical services of the area are organized around it (*31*).

The community health and medical center can help realize many of the goals previously discussed: Coordination of home, clinic, and hospital care; organized professional staffs with hospital offices; unification of in-patient and out-patient services; provision of diagnostic services for private practitioners; cooperative emphasis on preventive medicine and health education; and, finally, regional affiliations with outlying health stations and with metropolitan medical teaching centers. Through development of such community health centers, within the framework of an organized medical service program, the highest standards of patient care can be achieved.

SERVICES

A major criterion of medical adequacy is that the services rendered be comprehensive, balanced, and afford the patient a maximum continuity of care. In the previous discussion of personnel and facilities much has also been said of the content and organization of services. This section will further consider some of the special aspects of medical service which have a particular bearing on standards.

Preventive care

A most significant criterion of medical care of high quality is the degree of emphasis placed upon prevention of disease. The unfortunate separation of preventive and curative medicine—historically developed in the independent activities of public-health officers and private practitioners—is incompatible with the highest standards of modern medicine. "Prevention" no longer deals only with preventing the initial onset or occurrence of disease. It also means preventing the continuance or progress of disease which has already occurred; it means preventing the development or persistence of disability or invalidism, and of dependency, destitution, and other undesirable social effects. In other words, effective preventive service requires prompt, comprehensive, and continued personal care as well as community service of the kind traditionally associated with public-health activity.

Public health services.—A national health program should include provisions for the development of full public-health coverage in every area and for the integration of medical services with the activities of public-health agencies. Community organization of disease-control measures applicable to large groups of people can reduce considerably the incidence of illness. Public-health measures, if properly supported, can eliminate many of the preventable diseases now adding to the costs of medical care and public assistance. Provision of optimum community health protection allows the greatest possible application of medical care funds for diagnostic and therapeutic services in conditions not controllable by present-day mass methods (*32*).

Preventive medical care for the individual.—Effective preventive service requires not only close coordination of the medical care program with that of public-health agencies, but also strong program emphasis on individual health promotion and preventive care by practitioners. The effectiveness of the preventive work accomplished reflects in large degree the extent to which financial barriers between the patient and the practitioner have been removed. Good preventive care requires the elimination of special charges for initial or any other visits to the physician or clinic. It implies the geographic availability of services, as provided through coordinated regional networks and special incentives for rural practice. It makes essential the placing of administrative emphasis upon effective home and office care, diagnostic services for ambulatory patients, and simplification of administrative procedures in the provision and receipt of personal care.

The medical services of the program should also facilitate appropriate periodic health inventories of selected classes of individuals (*33*). Provision should be made—in conjunction with public-health agencies—for mass screening programs utilizing such newer techniques as the 70-millimeter chest X-ray and the microchemical diabetes test. Such health inventories are made feasible only by the removal of the financial barriers confronting the supposedly healthy individual and by the assurance of medical care for disorders which come to light. An essential component of these appraisals should be health guidance for the entire family.

Social and conomic aspects of medical care

Medical service of the highest technical quality is frequently ineffective if rendered without regard to the social, psychological, and economic factors affecting the patient's condition. Good clinical care involves treatment of the patient as a "whole person," as an individual functioning in a definite social environment, rather than as an impersonalized example of an organic pathological disorder (*34*). In the modern technical maze of diagnostic equipment, laboratory tests, special consultations, complex hospital routines, and the like, the tendency to lose sight of the individual patient is great. Comprehensive study of the patient is therefore necessary, involving all aspects—whether related to home, occupation, income, diet, or other factors—which are relevant to the patient's illness and his restoration to health. Diagnosis and therapy should be planned in careful relation to the realities of the patient's socio-economic situation. Clinical services should be closely correlated with other programs of social welfare, including vocational rehabilitation, housing, recreation, and other services. Professional standards in a national health program should continually be concerned with the social factors influencing the patient's recovery and with the effective utilization of all resources, within medical agencies and in the community, for meeting his needs.

The recent tendency to deal with the family as the unit of health care is an effective approach to the consideration of social and environmental aspects in medicine (*35*). It represents one effort to recapture the valuable relationship that existed between the old-type family practitioner and his patients. Medical-service teams operating in community-health centers can deal effectively with the health problems of whole family groups and can promote hygienic habits through family health-guidance activities. Significant developments of family health centers are under way in many countries, particularly England, South Africa, Canada, Sweden, and the Soviet Union (*36*).

A national medical-care program can promote the principle of family care in community health centers in at least three ways. Under the plan, the entire family group would be eligible for similar services. Guaranteed payments to practitioners and hospitals make possible the maintenance of health centers in any community, particularly if high priority is given for capital construction grants to these facilities. Finally, the regional pattern of organization can assure needed specialty services for small health units through their functional ties to nearby better-equipped hospitals.

Psychiatric services

It is becoming increasingly recognized that the isolation of psychiatric from general medical services is mutually detrimental and hinders the development of services of high quality. The current interest in psychosomatic medicine indicates that the health professions are receptive to the possibility of bridging this gap. A national health program, properly oriented toward mental health, can provide the necessary leadership and material basis for achieving this purpose. It can stimulate the development of mental-hygiene clinics and psychiatric units as regular, rather than exceptional, services of the general hospital. Through encouraging the inclusion of psychiatry in medical groups, clinics, hospitals, and regional plans, a national health program can promote the integration of skilled psychiatric personnel into all general health and medical services. It can help educate physicians and other health workers to understand the importance of psychological factors in the management of their patients. Most important of all, it can bring about an extensive development of preventive psychiatry, utilizing services such as well-baby clinics, school-health programs, and all other community resources for the widest possible dissemination and application of sound principles of mental hygiene.

Continuity of medical care

High standards for medical service require more than adequate personnel and facilities. The patient must be guaranteed the advantages of continuous and interrelated care. Such care involves attendance by the same physician, dentist, nursing team, social worker, and so forth, throughout the course of the patient's management, as far as is practicable and desirable. It will be modified, of course, by the need of consultants, referrals to differently qualified personnel, and freedom of choice and change on the part of physician or patient. Nevertheless, the principle of continuity of care should enable the patient to remain under coordinated management throughout all phases of treatment.

Continuous care must not only be well integrated but also complete in its various aspects. High quality of service is difficult to achieve unless domiciliary, ambulatory, and institutional care are all systematically developed. The full range of health service, from prevention through rehabilitation, must be integrated from the patient's point of view. Professional personnel must be free to render service wherever indicated by the clinical and social factors in the case. The highest standards are not achieved when the services of an organized program are limited to one particular type of care; for example, in-patient hospital services. Full continuity of care permits a medical plan to exploit the advantages of home care for children, the chronically ill, mild cases, and others who might benefit in selected instances (*37*). It makes possible saving of hospital beds, reduction in length of hospital stay, easy transfer of hospital patients to convalescent facilities, and other service and administrative advantages. For rural and suburban areas this concept of continuity and completeness of care can best be realized through the regional network of medical facilities and functions described above.

Care for chronic illness

The principle of continuity includes the concept of service for long-term illness and disability. Good medical care does not stop at the provision of services necessary to control the acute episodes of disease. Scientific care of the patient includes chronic hospital, convalescent, rehabilitative and nursing-home services wherever necessary (*38*). Adequate programs of home care are vital in the proper management of many chronically ill individuals.

A recent joint statement of the American Hospital Association, the American Medical Association, the American Public Health Association, and the American Public Welfare Association has outlined recommendations for optimal service for the chronically ill (*29*). The statement recognizes that the care of long-term illness presents certain special aspects, but emphasizes that it cannot be isolated from general medical services without incurring serious danger of deterioration in the quality of care.

Rehabilitation

The vast experience of those responsible for rehabilitation of the wounded during the recent world war has renewed professional interest in this long-neglected phase of medical care (*39*). It is now widely recognized that treatment is not completed when the clinical disorder is eliminated or stabilized. Wherever possible the patient must be restored to a useful and self-sufficient place in society. This involves the coordination of medical, psychiatric, physiotherapeutic, educational, vocational, and social services. As in the case of services for the chronically ill, rehabilitation programs should provide for maximum continuity with earlier phases of care, and should be developed in close association and coordination with general medical services and facilities.

Discriminatory practices in health services

The persistence of discriminatory practices in professional fields continues to depress the quality of medical care (*40*). Minority population groups are too frequently denied needed medical services because their members are refused equal opportunity for professional education and advanced training. Physicians and other professionals from these minority groups are turned away from the very resources that would maintain the quality of their work—hospital appointments, medical-society membership, referral arrangements, teaching affiliations, research opportunities, and the like. Patients, on the other hand, often find themselves barred from certain practitioners' offices, from entire hospitals, and from needed private accommodations, or else they are afforded cursory or substandard treatment that fails to satisfy their needs. Segregated facilities generally are below the standard maintained by other institutions in the community. The entire picture of discrimination in health service is inconsistent with the high precepts of medicine and serves to perpetuate some of the most glaring examples of low quality of medical care in the Nation. A national health program should eliminate all barriers to needed services, social as well as economic and geographic.

Role of the public

In developing a medical-care program of good quality, the public has a vital role to play, both as responsible members of the community and as patients on the receiving end of the services. A high-caliber medical service can be effective only if properly utilized. The recipients must be taught, through carefully designed programs of health education, when to seek medical care, how to use the various resources of the program, and how best to follow the recommendations and directions received from professional attendants. Appropriate educational activities in the program will stimulate public desire for high quality of service and will indicate the disadvantages of unnecessary demands for care. An intelligent, cooperative, and sensitized population is quick to detect flaws in standards of service and can make real contributions to the program by timely and judicious comments on quality of care received.

As supporters of and participants in a national medical-care program, the public has many opportunities for enhancement of service standards. Full lay representation on policy and planning boards and on advisory committees helps to insure equitable consideration of the patient's point of view. Active understanding of operations and procedures affords recipients a greater sense of personal identification with the plan and is conducive to better public response. In this connection, trained health educators have a vital role to play in facilitating effective operation of the program.

FINANCING

An essential factor in medical care of good quality is that of sound and adequate financing, so designed that no economic barriers restrict the provision of needed medical services, and that fair and adequate renumeration is provided to all those furnishing the care. Good medical care, although purchasable, is not cheap. As Sir Arthur Newsholme has stated, it should be considered worthy of generous support (*41*). The financial savings to society produced by preventive care, early diagnosis, prompt treatment, and effective rehabilitation are actually far in excess of the original cost of such service, in terms of increased productivity and reduced public outlays for care of persons with chronic illness, disability, insanity, dependency, and destitution resulting from disease.

A fundamental principle of quality in medical care, then, is adequate financial support for service and administration. Meager financing can effectively limit the scope of service offered or demanded, can restrict the number and competence of participating personnel and facilities, and can postpone indefinitely the proper organization of available resources. As a first step in the achievement of high medical standards, the economic barriers between the best of medical resources and their application to the requirements of optimum public health must be removed.

Economic barriers to medical service

The removal of financial deterrents in the provision of medical care has immediate and lasting effects upon the quality of that care. These include:

1. Encouragement of preventive services, since recourse to medical attention during health and early illness is no longer financially penalized.

2. More adequate use of laboratory, consultant, and institutional services, thus promoting full use of all modern scientific weapons in the war against disease.
3. Improvement of doctor-patient relationships, by the elimination of extraneous financial considerations from the consultation room.
4. Assurance of adequate income to professional personnel and of economic protection against the cost of illness to patients, thereby promiting better provision and reception of medical service.
5. Continuous support of medical education and research within the financial arrangements of the program.

Financial stability

The 1944 APHA statement (*1*) recommends that "A national plan should aim to provide comprehensive services for all the people in all areas of the country. * * * Services should be adequately and securely financed through social insurance supplemented by general taxation, or by general taxation alone. Financing through social insurance alone would result in the exclusion of certain economic groups and might possibly exclude certain occupational segments of the population." If such a program, providing service for the entire population, cannot be accomplished at the outset, the plan should at least aim toward the goal of universal coverage, and this goal should be achieved as rapidly as possible.

Adequate and stable financing is the necessary foundation for a medical-care plan of sound structure. If social insurance is utilized, the maximum financial stability and adequacy is obtained by substantial supplementation with general tax funds and by coverage which assures the broadest possible spread of risk and the widest possible sharing of costs. Differential selection of the best risks by private insurance agencies (so-called "contracting out") should not be permitted because it would leave the national plan in an adverse financial position, greatly complicate administration and public participation, and expose the program to commercial exploitation.

Financial stability need not depend upon procedures such as "barrier" or extra payments, curtailment in duration of service and the like, which restrict unduly the scope of medically necessary service. A Nation-wide program, with resources organized for maximum efficiency of service and with payment methods which permit economy of operation, can achieve a highly stable financial basis. However, some limitations on drug, dental, hospital, or related services will be necessary, at least initially, until the medical and administrative resources of the Nation are more adequately developed and more efficiently organized.

Whether the medical-care program is financed through social insurance supplemented by general taxation, or by general taxation alone, it is recognized that additional support from general tax funds is necessary for construction of needed facilities, for professional education, for research and other grants-in-aid, and for similar functions. Such provisions of a national health program are essential to the achievement of a high quality of care.

ADMINISTRATIVE PRINCIPLES

The final criterion of medical care of high quality relates to the efficiency of administration in organized programs. The foregoing sections have outlined those elements of medical service which constitute "good" health care. Such a structure neither develops spontaneously nor functions independently of expert supervision and direction. The efficiency of administration of medical-care plans determines—to a considerable degree—the actual quality of the service received by the patients.

The purposes of effective medical-care administration are: (1) To assure early, prompt, and thorough service; (2) to maintain high standards; and (3) to guarantee continuity and consistency of care (*42*). An administrative system that consciously strives to achieve these goals can take advantage of the now considerable experience that has been accumulated in this and other countries. A few of the administrative principles most directly related to quality of service might be briefly discussed. Many have already been implied.

Policy and planning

Standards of service satisfactory to both the public and the professions can be achieved only when equitable representation of both groups is provided on all policy-making and advisory bodies. As a basic principle, the representatives of no one professional or economic group should have majority control of policy determination. Equitable voice should be given to consumers as well as providers of service, to farm and labor representatives as well as civic and industrial leaders, to dentists, nurses, social workers, and related personnel as well as physicians and hospital administrators. Whenever professional or technical matters are involved, decisions should be made by appropriate professional and technical bodies. The basic control of the program, however, must never be relinquished by the people themselves, acting through elected legislative representatives and the appointed administrative staff.

Those in charge of administration should be experts in this field, specially trained, adequately compensated, and chosen on the basis of a merit system. Competent in purely clincal or academic functions does not necessarily qualify a professional person for administrative responsibility. Quality of medical service and efficiency of operation can also be improved by the regular utilization of expert consultants in the various technical phases of the program.

Maintenance of high standards requires constant self-evaluation in the light of the rapidly advancing frontiers of medical and organizational knowledge. A national health program must engage in continuous appraisal of its own operations and must promote all opportunities for controlled experimentation in both the science and the method of medical care. There exists currently a serious need for objective criteria by which the quality of service in an operating medical-care program can be appraised (*43*).

Administrative safeguards of quality

All administration should be in the hands of a single responsible agency at each level of Government. At the outset a clear definition of function is essential for each of the administrative units, for all staff personnel, and for participating professional persons and institutions. The program should be decentralized for flexibility and feasibility of local application in providing and paying for services.

Eligibility requirements in a program of universal coverage would be limited to the single factor of medical need. If coverage is less than universal, the extent to which the program approaches the goal of complete national coverage will largely determine the degree to which restrictions on age, sex, residence or settlement, income, occupation, and the like can be minimized.

In order to promote medical services of high quality, the use of the means test as a criterion of eligibility should be eliminated in a national health program (*44*). The personal indignity of financial investigations prevents many individuals in serious need of medical service from seeking care under means-test programs. A basic requisite for good medical service is a healthy relationship between providers and consumers; recipients of charity medicine are not in a position to insist on a high quality of care.

Good medical care is not promoted when services are rendered on the basis of a double standard—one for "paying patients" and one for "charity cases." Recipients of public assistance should be included in the national medical-care program, and the welfare status of such persons should be unknown to those providing the care.

The publication and periodic revision of administrative procedure manuals would help all participating personnel to understand and attain the desired standards of performance. These manuals should contain the administrative policies and procedures of the program and such professional routines as are promulgated by professional authorities and advisers connected with the plan (*45*). If efficiency rather than inflexibility of service is to be attained, such manuals should be liberally interpreted and frequently reviewed.

Free choice and change of practitioner, medical group, or facility should be maintained, subject to geographical limitations and provisions for proper selection of specialists. Professional personnel should retain the right to accept or reject patients, with the provision that the professional participants in an area are collectively responsible for rendering needed services to all persons who do not elect or who are not accepted by a specific physician.

Various administrative devices are valuable in controlling abuses and promoting quality of care. The right of administrative review should be retained by central and local administrative jurisdictions: by this means systematic checks on service records and billings can be maintained. This is especially necessary under the fee-for-service method of payment (*6*). Professional review of case records selected at random has produced dividends in terms of high quality as, for example, in the various programs of care for crippled children.[9] The proper discharge of administrative responsibilities includes the right of the operating agency to ascertain the caliber of the services for which it is paying.

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[9] See procedures of the crippled children's program, U. S. Children's Bureau, Federal Security Agency, Washington, D. C.

Automatic statistical audits of services and costs provide an accurate and impersonal check on the standards of service. Comprehensive systems for the tabulation and analysis of all operational data make possible the detection of those consumers and providers of service who deviate significantly from the average experience of the area in any given time period (*47*). (Such deviations do not, of course, necessarily represent "abuses" detrimental to the program.) The various details of program operation can be studied and adjusted according to analyses of accumulated experience. Relative efficiency of different service districts can be compared. Experience with different methods of care, with different categories of illness, with different groups of beneficiaries can be appraised and applied to the development of better methods and procedures. Most abuses of the plan—either excessive demands for service on the part of patients or improper activities on the part of professional persons—can be identified and evaluated through the systematic application of statistical methods in administration. This technique does not penalize or inconvenience the great majority or participants because of abuses by a few individuals, as do such methods as review of service bills and proration of payments.

The requirement of prior administrative authorization for selected services of an unusually expensive or doubtfully efficacious nature is another useful control method. In this way the local area medical administrator, with the help of advisory bodies when warranted, may exercise some control over the economy and efficiency of the new system. Such required authorizations should be reduced to a necessary minimum and should never be allowed to interfere with the timely provision of needed medical care. High quality of care is promoted by the early and easy access of patients to medical attention—a consideration which outweighs in over-all importance the relative infrequency of unnecessary demands for service. For this reason, extra "barrier" charges for first visits, home visits, health examinations and so forth, are seldom justified in the name of administrative control.

The method of paying participating professional and other personnel should be one which will encourage preventive medicine and a high quality of service. The fee-for-service method puts major emphasis upon sickness rather than health and upon quantity rather than quality. It hinders appropriate referral of patients because it provides an economic incentive for the physician to retain his patient. This factor, in addition, seriously limits the effectiveness of regional hospital plans by impeding the referral of patients to district and regional centers for necessary consultant services. In an organized plan, fee-for-service is cumbersome, requiring itemized billing and auditing and thus a great deal of paper work. It is also the most difficult method under which to control use of service either quantitatively or qualitatively and is, therefore, the most expensive method to administer in a medical-care program. Widespread use of unlimited fee-for-service might well make physicians' services so costly as to force economies in other essential health services such as hospital, nursing, or dental care. If, on the other hand, a ceiling is set on the pool of funds from which fee-for- service payments are drawn, excessive multiplication of services by a few physicians may serve to force pro rata reductions in all fees paid, thus penalizing the more conscientious doctors. Such a result has been seen in this country in the experiences of voluntary prepayment plans with attempts to provide payment for comprehensive physicians' services by fee-service. In Great Britain, under their former national health-insurance program, physicians in some localities at first elected to be paid by fee-for-service, with the pool of funds limited to the same amount as was available under capitation. Some doctors provided excessive numbers of services; all fees were forced downward pro rata, thus placing conscientious doctors at a serious disadvantage. In the end, by vote of the physicians themselves, fee-for-service was abandoned. In other countries, where fee-for-service has been retained, it has been found necessary to modify this method of payment through combination with capitation or basic payments in addition to proration.

Other methods of payment such as capitation, part-time or full-time salaries, either separately or in combination, provide steady incomes for physicians as compensation for their time and skill. Unlike the "piecework" fee-for-service system, these methods pay amounts which are not directly related to the number of services furnished to sick people. As a result, physicians paid in this manner have an added incentive to keep their patients as healthy as possible, and so to reduce total demands upon their time, especially for the care of sickness. These methods, therefore, encourage preventive medicine and minimize incentives for unnecessary multiplication of services. In general, they place emphasis upon quality rather than quantity, and upon maintenance of health rather than cure of sickness, as the foundations of the doctor-patient relationship.

At the same time, capitation or salary, if not properly applied, can have certain disadvantages. Physicians may offer too few rather than too many services or even be led to do indifferent or careless work. They may be tempted, under capitation, to accept larger lists of patients than they can care for adequately. These problems can, however, be solved with less difficulty than those arising from the fee-for-service system. In order to safeguard quality, reasonable limitations should be placed on the number of persons for whom physicians undertake to provide service. The fact that patients would have freedom of choice (and of change) among participating individual physicians and medical groups would furnish a desirable competitive element, far more conducive to high quality of care than is mere competition for large numbers of fees. In addition, good work can be encouraged through supervision of standards of care by appropriate professional committees, locally selected * * * with the advice of participating professional personnel. By removing or minimizing the incentive for quantity inherent in fee-for-service, the program could make careful, deliberate work, rather than the multiplication of services, the principal motivation for a physician to improve his professional and economic status.

The most satisfactory application of capitation or salary is found in group medical practice. In a group, the compensation of each physician depends not only upon his own efforts, but also upon the success of the group as a whole and the judgment of his fellows regarding his contribution to the group's success. The reputation of the entire group is at stake in the satisfaction of patients with the services of all physicians in the group. Under these circumstances, every physician naturally desires to do well in the eyes of both his patients and his fellow-physicians. These motives, which arise from the cooperative (rather than competitive) atmosphere in group medical practice serve largely to offset any disadvantageous effects of payment for physicians' services through salary or capitation.

Whatever methods of compensation are used, highest medical standards require that full payment be made to medical groups, full-time hosiptal staffs and other professional teams, in addition to individual practitioners.

Methods of payment to hospitals and other institutions are equally relevant to good quality. All experience indicates that the problems involved in paying for hospital service are complex and difficult. Payment on a per diem rate which is uniform for all hospitals in a given area leads to mediocrity by penalizing the hospital which, in an endeavor to improve services, raises its costs above the average. On the other hand, payment to hospitals on a cost basis, while it gives ample scope for hospitals to improve services, provides no incentive to increase efficiency and keep costs at reasonable levels. The so-called point-value system of Agnew 48 attempts to reward quality and thoroughness of service, but has proved unwieldly in the recent experience of the Saskatchewan Hospital Services Plan (*49*). Perhaps the best approach would be to pay hospitals on a cost basis, with different ceilings for hospitals providing services of differing scope and standard. No system for paying hospitals is workable in the absence of good cost accounting on a uniform basis (*50*). This entire subject requires further study and exploration.

Rates of payment—when flexible, adequate, and appropriately related to skill, experience, and responsibility—are important elements in the attainment of high standards. Payments should be sufficient but not excessive, in order to improve professional standards and minimize financial competition among health personnel. Rates of payment need not be uniform nationally, but may take into consideration regional variations in standards, as well as varying degrees of qualification on the part of participating personnel. When rates of payment depend upon qualification as a specialist, technician, or the like, the standards for such designation should be objectively established in advance by competent experts in the particular field.

Collection of fees over and above payment received from the organized program for a particular service should not be permitted if services of equal quality are to be rendered to all individuals and if economic incentives are to be divorced from professional judgments. This, of course, does not exclude payments for services rendered to private patients outside of the plan.

Standards for personnel and facilities

Objectively determined qualifications should govern the participation of general practioners, specialists, and other personnel. Physician participation should be restricted to those with degrees of doctor of medicine and licenses to practice medicine. Similarly, appropriate educational and licensure requirements are necessary for dentists, nurses, and auxiliary personnel. Standards for medical specialists should be established and administered on the basis of specialty-board certification and evaluation by a medical council of the individual's previous performance, standing in the medical community, and demonstrated ability. Insofar as practicable, nonmedical practitioners such as optometrists or podiatrists should not be entitled to payment for services except under medical supervision or upon medical referral.

Supervision of professional services by professional persons is essential if the best of care is to be provided. Satisfactory professional supervision has long been an established criterion for approval of hospitals, clinics, and other medical organizations. Visiting teams of specialists in outlying areas, senior staff supervision of hospital work, mutual supervision in group medical practice, professional control of technical and auxiliary services, periodic review of clinical case records by qualified authorities—all such supervisory activities are necessary components of a program of good medical quality.

Proper medical standards imply that each practitioner will have sufficient time to render adequate service to his patients. Administrative limitations on the total number of patients for whom a participating physician may obligate himself to furnish care are, therefore, in the interest of good medical service, and should be developed with professional advice and recommendation.

The plan should provide special incentives for the settlement of health personnel in rural, depressed, and otherwise undersupplied areas. Such incentives might include specially provided equipment and facilities, loans or grants for intitial expenses during the setting up of a new practice, assurance of adequate annual income, functional affiliation with urban resources, and the like. Such special provisions are necessary if the quality of service in outlying areas is to approach the standards of metropolitan medical centers (*51*).

Standards for the participation of each type of hospital should also be established by the administrative agency and evaluated periodically with the advice and counsel of appropriate technical groups. A major requirement for hospital participation should be the efficient organization and operation of the professional staff. Coordination between in-patient and out-patient departments (*52*) and between both of these and home-care services, is another essential element to be considered in evaluating hospital services. Approval for participation in the national health program should be reserved for facilities meeting at least minimal standards, with hospitals accepted for complete or limited services on the basis of objective qualifications. Financial and technical assistance should be made available to nonapproved institutions interested in meeting the standards of the program.

SUMMARY AND CONCLUSIONS

The quality of medical care neither deteriorates nor improves automatically with the mere establishment of a national program of medical care. The standards of service achieved by this—or any—program depend directly upon the human and material resources available, upon their organization for service, and upon the efficiency of their utilization. A poorly designed and badly operated program can—and would—render the provision of good health service impossible. On the other hand, the very nature of a Nation-wide plan provides a hitherto unparalleled opportunity for the development of services which can satisfy the highest criteria of good medical care.

Medical care of good quality requires well-trained personnel, adequate facilities, and a reasonably comprehensive scope of service.

Highest standards of medical care are achieved only with the wise and efficient organization of these resources. This key factor determines the actual effectiveness of the personnel, the facilities, and the services.

Efficient organization of personnel involves group medical practice in health centers; of facilities—regionalized planning for coordinated hospital net works; and of services—continuity through the full range of health care. These emerge, therefore, as the organizational triad most essential to improvement of the quality of medical care.

When sound financing and competent administration provide the firm foundation for such an organizational structure, high standards of service are protected. When provision is made for generous support of education and research in the health services, the constant elevation of these standards is assured.

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Senator MURRAY. The next witness is Harvey W. Brown.

Mr. Brown, Senator Donnell is anxious to leave the hearings at this time to attend some other hearing that he is interested in, and he wanted to know if we could defer your examination for some other time.

Mr. BROWN. I would be very happy to accommodate him. I might say that tomorrow at noon I leave for the west coast.

Senator MURRAY. How late could you stay here this afternoon?

Mr. BROWN. Until 5 o'clock, if need be.

Senator MURRAY. If you do not mind, then, Mr. Brown, we would like to recess for about a half an hour, which will give Senator Donnell an opportunity to attend his hearing and return. And then we can finish your testimony.

Mr. BROWN. Yes, sir.

(A short recess was taken.)

Senator MURRAY. We will resume.

Mr. Brown, you may proceed as soon as you are ready.

STATEMENT OF HARVEY W. BROWN, PRESIDENT, INTERNATIONAL ASSOCIATION OF MACHINISTS; ACCOMPANIED BY GEORGE NELSON, GRAND LODGE REPRESENTATIVE, INTERNATIONAL ASSOCIATION OF MACHINISTS

Mr. BROWN. I am Harvey W. Brown, president of the International Association of Machinists.

Before proceeding, gentlemen, I do hope I will not be detained after 4:30 if at all possible.

Mr. Chairman and members of the subcommittee, I appear here today to present the views of our association on the bills now before this committee, which purport to improve our Nation's health. To be consistent and yet concise, I will refer to each in their numerical order.

Examination of S. 1456 shows that it recognizes our need for the strengthening of present health resources. While, no doubt, this bill is well meant, it does not provide adequate protection or go far enough to solve the problem of medical care for the vast majority of our people. In addition, this bill contains two principal proposals which neither the working people of this country nor their unions can accept. The first is that set forth in part A, Declaration of Purpose, section 701 (b). This proposes to make high-quality hospital and medical care available to all persons in each State by "encouraging and stimulating voluntary enrollment in prepayment plans for hospital and medical care, with emphasis on employer participation." For the past several years many unions have proposed and negotiated prepaid health plans as a part of collective agreements with their employer. We acknowledge that, at best, these plans have been inadequate. Under the language of this section, I seriously question whether employees or their representatives could continue their present collective endeavors. I also question if this provision does not give the employer the sole discretion to set the standards of a prepayment plan contrary to the wishes of his employees.

The second proposal to which we take special exception is that embodied in part C of section 701. While this part proposes protection to persons financially unable to pay, actually it merely continues our present State practice of medical dole. This is confirmed by examination of the enabling sections which provide for service cards to those unable to pay for subscription charges of a prepayment plan. This type of health program, at best, only provides a means and not a solution for the medically indigent.

S. 1456 is also deficient in a number of other respects. Its scope does not cover enough of the medical needs by failure to provide for protection against costs of routine illness, preventive medicine, and the services of a doctor or specialist in home or office. Its administration and coverage, limited to voluntary plans, plus those who cannot afford to join voluntary plans, is wholly inadequate to solve our national health problems. Left on a voluntary basis, in the face of ever-present selfish interests, together with present State restrictions on such voluntary plans, can only result in a cost to the people it proposes to cover beyond their economic means.

For these reasons and the fact that this bill is based on the principle of public medical charity, we cannot endorse or support this measure.

Turning attention next to S. 1581, I wish to say at the outset that in my opinion this bill represents an indirect endorsement to a major portion of S. 1679. It recognizes the basic need for a health law by proposing to enact the National Health Act of 1949. It lists as its purpose—

> to coordinate the health functions of the Federal Government in a single agency; to authorize grants to States for extending and improving the provision of medical, hospital, and dental services; to authorize grants to States for providing health examinations for school children and medical and dental treatment in certain cases; to amend the Hospital Survey and Construction Act (Title VI of the Public Health Service Act) to extend its duration and provide greater financial assistance in the construction of hospitals; to amend the Public Health Service Act to authorize grants to States and political subdivisions in the development and maintenance of local public-health units; to authorize studies and grants for increasing available manpower in the health professions; and for other purposes.

Section 2, paragraph 1 of its finding clause confesses that health and medical functions are widely scattered through many agencies in the Federal Government with the resultant confusion and duplication of effort, and that because of this diffuse organization State health administrators and other State officials find it necessary to submit plans and budgets to numerous Federal officials responsible for health programs under a large number of unrelated statutes.

Paragraph 2 of this same section admits that there are inadequacies in the distribution of public-health services and of medical, dental, and hospital services in the United States, and a shortage in professional personnel who provide such services, with the result that some persons are unable to secure such services to an adequate degree.

I have quoted these parts at some length because they emphasize the need for prompt action to a problem which has long been recognized as in need of correction. This need is also recognized and provided for in S. 1679, and in this respect both S. 1581 and S. 1679 contain parallel objectives. However, at this point all comparison ceases.

We are unalterably opposed to S. 1581 because it rests on the un-American principle of charity medicine. Instead of providing the plain people with a constructive program based on their participation through a comprehensive insurance program, it subjects them to the fear and indignity of a "means test."

Despite the recent quotation credited to the author of this bill to the effect that "as long as four-fifths of the people remain their own bosses, there is no serious infringement of the principle of liberty for the entire people," this proposal would set up class citizenship on the basis of the dollar criteria.

My examination of this measure prompts the conclusion that a person would have to bow to the humiliation of an investigator before being certified to accept charity medical care. This is the very condition that lack of planning and failure to enact a comprehensive medical-care program has forced upon the financially unfortunate today. It is the elimination of this condition that we have long advocated and urged.

We are also critical of its method of administration. It stipulates that the director shall be a physician. This in itself encourages the abuses now practiced by selfish medical societies. It provides a stepping stone to monopoly control while ignoring the taxpayer and consumer groups who must furnish the money to keep it in operation.

Most intolerable of all, this condition would be created without meeting the real health needs for the majority of the population. S. 1581 proposes no system that I can find which would enable the plain people of this country, four-fifths of our population, to have medical care without hurdling the dollar barrier.

From our analysis of the bills now being considered by this committee, I am convinced that only S. 1679 contains the requirements necessary to a successful health program. It contains sound proposals of enabling legislation and retains the principles of our American democracy.

Title 1 provides for the authorization of Federal aid for the education and training of professional health personnel. This will be carried out by the expansion and improvement of existing schools, together with the construction and equipment of new schools. State scholarships are awarded to provide a means and incentive to increase enrollment in schools of medicine, dentistry, dental hygiene, nursing, public health, and engineering. This title recognizes a need in which we have long been woefully weak. In fact, many people are today denied treatment when they most need it because of the shortages which exist in this profession. Reliable sources report that our medical personnel numbers only about 80 percent of what is needed. To correct this situation, it will be necessary to enroll and train within the next 10 years a total of 15,000 doctors, 5,000 more dentists, and 40,000 more nurses, together with the necessary technicians. This requirement is over and above the expected production of such medical persons.

Title 2 gives the United States Public Health Service authority to establish additional institutes now vitally needed for research of those devastating diseases, such as diabetes, arthritis, and others which daily take their toll of our people in suffering and death. It gives to the Surgeon General the special advisory councils so necessary in this technical field.

Title 3 modernizes and puts a sound foundation under our need for more and better hospitals. By expanding the present appropriation of 75,000,000 to 150,000,000 we can go a long way in meeting the urgent need for 900,000 more beds. A condition which shows that 15 percent of our present non-Federal beds are in buildings which do not meet established standards and crowded conditions which make many hospitals virtual firetraps certainly cannot go unheeded. Persons making a study of our hospital conditions report that it will cost at least $5,000,000,000 to realize just half of our needs in the next 10 years.

This title also recognizes a basic need in our general health program by providing grants-in-aid so that the poorer States may obtain up to two-thirds Federal contribution, instead of the flat one-third, which is presently provided.

Titles 4, 5, and 6 provide for special aid for rural and shortage areas, expand the present law for grants-in-aid for State and local health work and for maternal, child health, and crippled children's services. This need is so widely recognized and accepted that I do not believe it is necessary to elaborate on them at this time.

Considering the final section, 7, we come to that title which to us is the very heart of this legislation. After careful study and recognizing the needs of our over 500,000 members—I want to pause there and make this statement. The term 500,000 members is an error. We have approximately 625,000 members and about 25,000 are in Canada. There are approximately 600,000 in the States.

These, plus their families, convinces us that the solution to medical care is a Federal system of prepaid personal health insurance. Our conviction is not alone based on technical and scientific charts or figures. To a great extent it comes from the first-hand knowledge that our families live under a constant fear of costly medical expenses which they cannot at present guard against.

This same fear used to apply to old age and unemployment, but our Government recognized this need and today, while inadequate, we do have a functioning system which has been accepted and endorsed by all the working people.

The reason I keep stressing the working, plain people of this country, is because they represent the bulk of our people who are the victims of our present inadequate health system. The well-to-do and the charity patients are, for the most part, adequately cared for. Presently voluntary plans, at best, can only supply a small part of the in-between group with partial financial support.

The dollar barrier to good adequate health care must be lifted for these people. That is why we endorse a system of health insurance as set forth in title 7 of S. 1679. It provides health insurance which is national in scope and would cover approximately 85 percent of the entire population, including employees and self-employed persons in business for themselves, as well as their dependents. This coverage would entitle them to medical and dental service from general practitioners and specialists, supplemented by home nursing care, hospital care, laboratory service, X-rays, expensive prescribed medicines, eye glasses, and specialist appliances.

This is accomplished in true democratic American fashion. It preserves the dignity of the individual and makes him an interested stockholder in his Government. The provisions in this measure refute totalitarian ideologies by explicitly providing for the free choice and change of doctor and dentist by the patient.

This also applies to the professional. Every doctor, dentist, nurse, and hospital is reserved the right to participate or not as they choose. They are guaranteed the right to accept or reject patients. Freedom from governmental supervision and control is likewise given to every hospital, clinic, and health group. Even the payments to doctors for services rendered are made flexible by leaving the method of payment to the decision of the doctors practicing in that area.

Administration of the program also recognizes our true democratic system by placing major responsibility in the hands of the people in localities where the services are rendered and received. Each State is given the right to administer the system through its own State agency, divided into local areas. This leaves medical matters in the hands of the professionals where it rightfully belongs. The consumer who pays the bills has a voice in such matters as administrative details, scope of benefits, eligibility of membership, fees, et cetera.

On the over-all level, a 5-man board under Federal administration assisted by an advisory council of both professional and lay people will lend their guidance and administrative assistance to the State agencies.

In conclusion, we are firmly convinced that the enactment of S. 1679 would be a great service to the country as a whole. It will make possible a system of just medical care to all on the basis of need and not on the size of their pocketbook. It will assure good quality care for all Americans regardless of race, creed or economic circumstances.

The United States is one of the few industrial nations in the world that does not have a system of prepayment for medical care as a part of its social-insurance system. While this in itself does not prove a case for or against health insurance, it is significant that no country has ever repealed such a system once it has been established.

Today the United States is looked upon for guidance and leadership by all the democratic peoples of the world. We have accepted this role. In order to justify this position we must show ingenuity and courage. Certainly when we are faced with the fact that each year 325,000 people die whom we have the knowledge and skill to save, it is evident that here lies one problem that does not justify our rightful claim of leadership.

There is ample proof that the overwhelming majority of American people support a national health-insurance plan. This is attested to by the fact that a poll conducted by the Washington Post in January 1946 showed that a majority of 70 percent of the people in the District of Columbia favored the enactment of a Federal insurance program. We are all aware that a drain of $27,000,000,000 from our Nation every year through sickness and disability can and will affect our long-range economy.

This is also true of the Nation's yearly loss of 4,000,300 man-years of work through bad health. We must assume the responsibility to do our utmost to insure that all people in this country attain the highest level of health care. It is for this reason that we ask for the speedy enactment of legislation proposed in S. 1679, which will correct our present inadequate standards.

Senator **Murray**. Thank you, Mr. Brown, for your very clear-cut statement. I do not think I can find any fault with the conclusions that you have arrived at here. I think your statement is made upon your own personal observations and long experience amongst the laboring classes of this country.

Mr. Brown. I might say, Senator, if you will pardon the interruption, this statement was prepared by the research department as the result of discussions by the executive council less than a month ago. They discussed it in the light of the information they gathered in their respective areas.

Senator Murray. Based on actual field studies of the situation in the country?

Mr. Brown. Yes, and as a result of that discussion the research department went to work and prepared this, and I was assigned the task to come here and present it in behalf of our association.

Senator Murray. I see, and the conclusions in the statement are in accord with your own views?

Mr. Brown. That is correct.

Senator Murray. I understand, Mr. Brown, that you are about to resign and retire from your position.

Mr. Brown. Yes, that is one of the reasons I want to get away. The organization is giving me a testimonial dinner this evening, and I have two more appointments before I go home and brush up for that affair. I am retiring at the close of June. The union constitution has a provision that when we reach 65 no person can longer qualify for office. So I am turned out to pasture at the end of June.

Senator Murray. Your constituents may want to have you as a candidate for the Senate or Congress.

I want to thank you for your appearance here today and for your many appearances here in the past. You have always been very candid and clear in your statements before the committee, and I think you have made a very considerable contribution to our efforts here.

Mr. Brown. I have tried to.

Senator Murray. I wish you good luck in the future.

Senator Donnell?

Senator Donnell. I just have a few questions, Mr. Brown.

This statement was not prepared by yourself?

Mr. Brown. It was not, Senator.

Senator Donnell. Senator Murray started to question you along the line of this statement representing the results of your own personal studies. However, I understood you to say you are in accord with the sentiments expressed?

Mr. Brown. Yes.

Senator Donnell. Would you mind telling us, please, who it is that actually prepared this statement, what particular individual or individuals in your research department?

Mr. Brown. I believe the gentleman who did most of the work in connection with this is one of our research department staff. He is here at present, Mr. George Nelson.

Senator Donnell. This gentleman right here?

Mr. Brown. Yes, sir.

Senator Donnell. And how long has Mr. Nelson been with your research department?

Mr. Brown. He has been there for several years. George, when did you come to headquarters?

Mr. Nelson. I have been in here 3 years, before that in the field with the union.

Senator Donnell. If you do not mind, I will ask Mr. Nelson a few questions directly along that line, Mr. Chairman.

Senator Murray. Certainly.

Senator Donnell. Do you mind telling us your age, please?

Mr. Nelson. Thirty-seven. I will be 38 in August.

Senator Donnell. Thirty-eight in August?

Mr. Nelson. That is right.

Senator Donnell. I am interested in August because that is my birthday. When is yours?

Mr. Nelson. Mine is the 23d.

Senator Donnell. Mine is the 20th, so I am just 3 days older than you are, that is, I should say, in point of days of the month.

What was your business or profession before you went with the machinists in their research department?

Mr. Nelson. I worked in the metal fabricating plant.

Senator Donnell. Metal fabricating plant?

Mr. Nelson. Yes.

Senator Donnell. Where did you work?

Senator Murray. I think it would be better if he came up to the table.

Senator Donnell. I think that would be fine.

Mr. Nelson. All right, sir.

Senator Donnell. Mr. Brown, you do not mind me asking questions directly of Mr. Nelson?

Mr. Brown. No, sir.

Mr. Nelson. I worked in Jamestown Metal Corp. in Jamestown, N. Y.

Senator Donnell. Jamestown, N. Y.?

Mr. Nelson. That is right.

Senator Donnell. That is the town in which they make these automatic voting machines; is that correct?

Mr. Nelson. That is correct.

Senator Donnell. Is that the plant you worked in?

Mr. Nelson. No, sir; I worked in the Jamestown Metal Corp. The plant that makes the voting machine is the Automatic Voting Machine Co.

Senator Donnell. And what was the first work you had? The work in Jamestown plant that you speak of, is that where you first began your work?

Mr. Nelson. Yes; that is where I started my apprenticeship.

Senator Donnell. What year was it that you started your apprenticeship there?

Mr. Nelson. You are going a way back.

Senator Donnell. Approximately, I do not care exactly.

Mr. Nelson. As I recall it was about 1926.

Senator Donnell. About 1926?

Mr. Nelson. That is right.

Senator Donnell. So you were about 16 years of age at that time?

Mr. Nelson. I was about 15½.

Senator Donnell. And you worked at your apprenticeship for how many years?

Mr. Nelson. I was in there under an apprenticeship for 2½ years, and then the apprenticeship was abolished and I was put on the production line.

Senator DONNELL. How long did you stay with that company?

Mr. NELSON. I was with that company until about 1940, when I went on full time for the machinists.

Senator DONNELL. And during the time that you were with the company you were engaged on the production line after you served your apprenticeship; is that right?

Mr. NELSON. That is correct.

Senator DONNELL. And by the production line you mean the production of what? What was it you were producing?

Mr. NELSON. We were making all-metal doors, trims, window frames, cowl shields for automobiles. We also started making radar equipment for the Navy and battleship interior equipment for the United States Navy.

Senator DONNELL. Then from 1940 up to the present time you have been with the international machinists in their research department?

Mr. NELSON. No; I was a fieldman at first. I was a business agent.

Senator DONNELL. Business agent for about how long?

Mr. NELSON. I was business agent for 6 years. I was an organizer prior to that.

Senator DONNELL. An organizer of the subsidiary unions of the international machinists; is that right?

Mr. NELSON. Yes.

Senator DONNELL. From 1940 until about when?

Mr. NELSON. I was an organizer before 1940.

Senator DONNELL. While you were still at Jamestown?

Mr. NELSON. That is right.

Senator DONNELL. And then you continued to act as organizer, did you, after you came with the machinists international organization?

Mr. NELSON. No; after I left as a business agent there, I came right down here to the research department.

Senator DONNELL. What I want to get at: You have been with the research department since what year, 1940?

Mr. NELSON. No; I have been in the research department here for 3 years. It will be 3 years September 1.

Senator DONNELL. And you were then organizer and business agent, and you succeeded from business agent over into the research department, is that right?

Mr. NELSON. That is right.

Senator DONNELL. Have you ever specialized along the study of health insurance plans of other countries, or anywhere? I mean to say have you ever studied the operation of compulsory health insurance in other countries?

Mr. NELSON. No. I have read some about it, about the British plan and the Swedish plan, and some of the other plans.

Senator DONNELL. I see. Do you mind telling us whether you have read any books on that subject or just have read newspaper and magazine articles?

Mr. NELSON. Mostly magazine articles, like the Journal of the American Health Association.

Senator DONNELL. Which Dr. Leavell was quoting here today?

Mr. NELSON. Which he was quoting, and things like that.

Senator DONNELL. Have you read any books at all on the subject of compulsory health insurance?

Mr. Nelson. I cannot say I have read any specific books on it—generally, in looking them over. I have not made a study of it.

Senator Donnell. I see. Thank you very much, Mr. Nelson.

Now, Mr. Brown, there are only one or two other matters I wanted to ask you about.

You say over on page 11 of your statement:

> Administration of the program also recognizes our true democratic system by placing major responsibility in the hands of the people in localities where the services are rendered and received.

I assume that you are referring to provisions in the bill with respect to local administrative officers and local professional committees and similar provisions, is that right?

Mr. Brown. Page 11, you say?

Senator Donnell. Page 11, about the middle of the page. Of course, I understand this was composed by Mr. Nelson and his associates.

Mr. Brown. Yes.

Senator Donnell. Did you compose this all yourself, Mr. Nelson, or you and your associates?

Mr. Nelson. I have had the assistance of the research director, Mr. Huhndorf, and other members, our economist and statistician, in developing the facts.

Senator Donnell. Now, returning to Mr. Brown.

> This language: Administration of the program also recognizes our true democratic system by placing major responsibility in the hands of the people in localities where the services are rendered and received.

Do you know what provisions of the bill are referred to in that sentence?

Mr. Brown. At the moment, no. I do not know those details, Senator Donnell. While I read all those bills, I did not study them very carefully, and my personal interest was in the principle and the purpose, and the absolute need for this kind of service.

Senator Donnell. I just wondered if in connection with that sentence as you now read it—though I understand you did not compose it and are not responsible for having it in here—if you had also read in the bill this language at page 129:

> In exercising their functions and discharging their responsibilities under this title local administrative officers and communities, local advisory committees, and local professional committees shall observe the provisions of this title, and of regulations prescribed thereunder, and of any regulations, standards, and procedures prescribed by the State agency.

And whether you would also observe on page 138 that the Board, that is to say the National Health Insurance Board, shall—

> make all regulations and standards specifically authorized to be made in this title and such other regulations not inconsistent with this title as may be necessary.

Do you recall having seen those provisions in the bill S. 1679?

Mr. Brown. I recall reading that; yes.

Senator Donnell. Those that I read?

Mr. Brown. Yes, sir.

Senator Donnell. No, over on the last page of your statement prepared by your research department reference is made to the poll conducted by the Washington Post in January 1946. I presume you do not know what the questions were that were asked of the persons who answered the questions in that poll, do you, Mr. Brown?

Mr. Brown. No; not the specific question.

Senator Donnell. So you would not be able to say.

Mr. Brown. Excepting I assume the question was whether they favor a Federal insurance program.

Senator Donnell. That is your assumption, but I wanted to know if you knew precisely what the questions were.

Mr. Brown. No, Senator; I do not know.

Senator Donnell. I observe with interest the fact that the poll to which reference is here made was in the District of Columbia, and that a majority of 70 percent of the people in the District of Columbia, it says, favored enactment of Federal insurance program. Of course, I take it, we would agree that a very large proportion in the District of Columbia are already governmental employees or the family of such. We agree to that, do we not?

Mr. Brown. I think that is correct.

Senator Donnell. I think that is all, Mr. Brown. I hope you have a pleasant evening.

Mr. Brown. Thank you.

Senator Murray. Thank you, Mr. Brown. I wish you much success and happiness in your future.

Senator Donnell. I join in that too, Mr. Brown.

Mr. Brown. Thank you, gentlemen.

Senator Murray. That concludes the hearings for today and we will recess until Monday at 10 o'clock.

(Whereupon, at 3:45 p. m., the subcommittee adjourned, to reconvene at 10 a. m., Monday, June 6, 1949.)

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Mr. BROWN. I think that is correct.

Senator DONNELL. I think that is all, Mr. Brown. I hope you have a pleasant evening.

Mr. BROWN. Thank you.

Senator MURRAY. Thank you, Mr. Brown. I wish you much success and happiness in your future.

Senator DONNELL. I join in that too, Mr. Brown.

Mr. BROWN. Thank you, gentlemen.

Senator MURRAY. This concludes the hearings for today and we will recess until Monday at 10 o'clock.

(Whereupon, at 5:40 p. m., the subcommittee adjourned, to reconvene at 10 a. m., Monday, June 6, 1949.)

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